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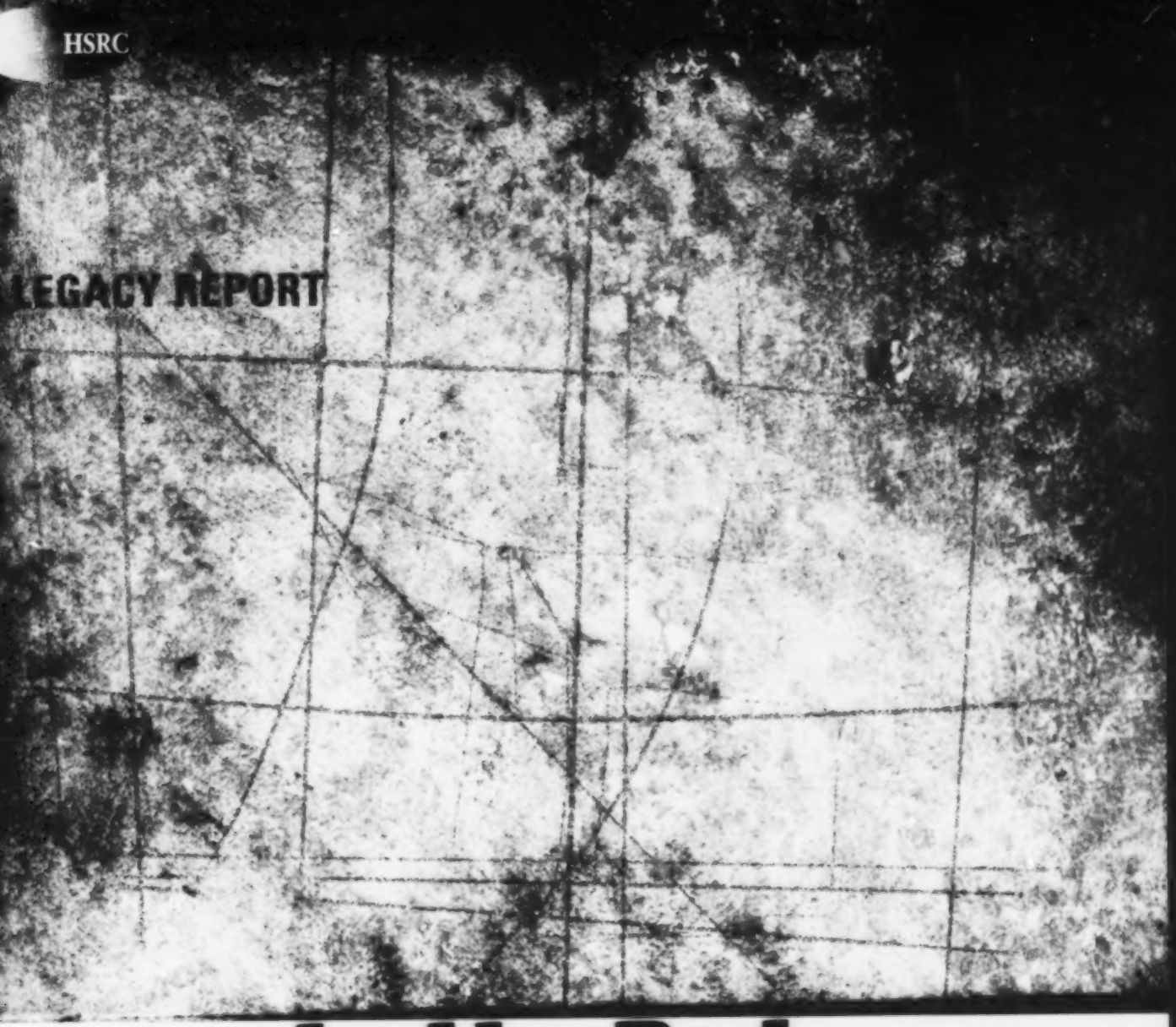
HSRC



LEGACY REPORT

# Looking Back, Looking Forward

MARCH 2000

# Looking Back, Looking Forward

## The Ontario Health Services Restructuring Commission (1996-2000)

# A Legacy Report

March 2000

M121

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## Vision of Ontario's Future Health System

*Our vision is of a sustainable health system that provides compassionate, comprehensive, high quality care to everyone who needs help to regain and maintain good health.*

*While reflecting community and regional differences, the system's health care providers work together toward the common purpose of meeting the publicly set goals, objectives, policies and priorities necessary to achieve Ontario's vision of health.* [1]

[1] The following Vision of Health was developed by the Ontario Premier's Council on Health Strategy and endorsed by all parties of the Provincial Legislature in the Spring of 1989: *We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work, and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender, or cultural background. Finally, we see everyone working together to achieve better health for all.*

# Health Services Restructuring Commission: Mandate

The Health Services Restructuring Commission ("HSRC", "the Commission") was an independent body established by the Ontario Government in March 1996. Its role was to expedite hospital restructuring in the province, and to advise the Minister of Health on revamping other aspects of Ontario's health services system.[2]

The HSRC's four-year mandate (1996-2000) consisted of three specific and closely related components:

- *to make decisions about restructuring Ontario's public hospitals;*
- *to provide advice to the Minister of Health about which health services would need reinvestment as a result of changes to the hospital system and changing needs of the population; and*
- *to make recommendations to the Minister on restructuring other components of the health care system to improve quality of care, outcomes and efficiency and help create a genuine, integrated health services system.*

[2] Schedule F of The Restructuring and Savings Act, S.O. 1996 Ch. 1 ("Bill 26") amended a number of health services acts. It also created the HSRC, sun-setting it after four years. The legislation/regulations gave the Minister of Health sweeping powers to reorganize Ontario's health system by direction. For example: to restructure public hospitals, reduce or terminate grants or loans, order boards of public hospitals to close, amalgamate, provide or cease providing services. The Minister could also by direction revoke the license of a private hospital and reduce or terminate its funding. Finally, the Minister could delegate her direction-making powers to other bodies. Upon recommendation of the Minister, the Lieutenant Governor in Council could replace a hospital board by a supervisor to ensure compliance with Directions. Appendix B provides a summary of the legislative/regulatory changes that established the HSRC and granted it its powers.

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David Naylor, Special Advisor (March 1996 – March 1998)

# A Message from the Chair

March 2000

In March 1996, the *Health Services Restructuring Commission* (HSRC) was established by the Ontario Government as an arms-length body to facilitate and expedite the process of hospital restructuring and to advise the government on other changes needed to improve the accessibility, quality and cost-effectiveness of the health and health care services provided to the people of Ontario

As our four-year mandate concludes, it is appropriate to reflect on the process of restructuring health services in the province to date and to make some final observations on the priorities and actions required to ensure that the system continues to evolve and develop to meet the needs of Ontarians into the 21st century.

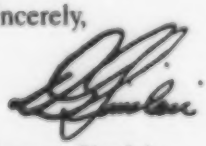
This report provides an overview of the work of the HSRC conducted between April 1996 and March 2000. Much has been achieved in the past four years to restructure Ontario's urban hospitals. We are keenly aware, however, that continued implementation of our directives to hospitals must be matched closely with timely reinvestments in other services (notably home- and long-term care).

Most of our work during the last year of our mandate focused on advice to the government on specific goals and changes required to create a more effective and integrated health system. The HSRC believes that bold steps must be taken quickly to make the elements of the health care system in this province (hospitals, home care, long-term care, primary care, etc.) more integrated and better co-ordinated. In the long term, it is our view that the government must play a much stronger role in governing – leading – the system and devolve the management of its elements to integrated health systems, organizations able to manage their resources to meet the particular needs for health services of the people in the communities, districts or regions they serve.

One of our biggest concerns is that progress toward greater integration will require a level of commitment and constructive thinking that exceeds current capacity given the many competing agendas. Without that commitment and thinking, much of the planning and management of emerging issues will continue to happen in the absence of a system perspective and our many health care 'silos' will be perpetuated. Furthermore, unless the people of Ontario are presented with a vision of the future health system they can "buy into", restructuring will probably continue to be perceived as nothing more than a cost reduction exercise rather than what it should be (and has been for the Commission) — the opportunity to renew and restore public confidence in the health system, our most cherished and single most expensive social program.

As the HSRC's mandate ends, it is our hope that decision-makers and providers of health services will seize the opportunity to create meaningful ways to make change and assess its impacts from a *system* perspective. We ask the Ministry of Health and Long-term Care, the key governing body, to build on the vision and legacy of the Commission's work and foster the creation of a genuine and effective health services system in Ontario.

Sincerely,



Duncan Sinclair
Chair, on behalf of the Commissioners

100-04686/

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# EXECUTIVE SUMMARY

## Background

*The Health Services Restructuring Commission* ("HSRC", "the Commission") was an arms-length body established under legislation by the government to expedite hospital restructuring in Ontario. In addition to directing hospitals to amalgamate, transfer or accept programs, change their volumes, cease to operate or make any other changes considered to be in the public interest, the HSRC was also charged with advising the Minister of Health[3] on changes required in other parts of the health care system. This advisory role included giving advice about reinvestment needed in other sectors/services to implement hospital restructuring. Finally, the HSRC was given authority to recommend ways and means to create a truly integrated, co-ordinated health services system in Ontario.

The HSRC was composed of a group of volunteers appointed by the Government of Ontario. The Commissioners were medical professionals, academic health science professionals, former hospital board members and others with expertise and experience in the health sector. Chaired by Duncan Sinclair, former Dean of Medicine, Queen's University (Kingston), a total of 12 individuals served as Commissioners during the HSRC's four-year term.

The Commission's initial focus was on hospitals in major urban municipalities, given that most of the hospital resource base was concentrated in eight communities – Hamilton, Kingston, London, Ottawa, Sudbury, Thunder Bay, Toronto and Windsor. After dealing with other urban centres in the province, the HSRC turned its attention to a review of rural/northern hospitals.

From the outset, the HSRC acknowledged that the status quo could not and should not be preserved. It used local planning processes as its starting point, but also applied a provincial perspective to ensure that its decisions met the evolving needs of Ontarians such as, population growth (based on 2003 population projections), changing patterns and practices of health care delivery, and the fiscal realities of the late-1990s and early 21st century.

The Commission was not charged with cutting costs. Its goal was to ensure the continuation of high quality, accessible and cost-effective health services. To develop restructuring options, the HSRC solicited input from District Health Councils (DHCs) and the local community. Following consultation, analysis, and consideration by the HSRC of a number of restructuring options, formal *Notices of Intention to Issue Directions* were issued to the affected institutions, community by community, together with reasons for the decisions made.

The affected institutions and other individuals and organizations were invited to submit representations in response to the *Notices*. Following consideration of the representations and additional analysis and review, the HSRC issued its final *Directions* together with accompanying recommendations (primarily related to necessary reinvestment in community-based services) to the Minister of Health.

The Commission's assessment of restructuring options and its decisions on the preferred option in each community were based on the criteria of quality, accessibility and affordability. Where an Academic

[3] At the time of the HSRC's establishment in 1996, the Minister of Health was known as the Minister of Health and her department, the Ministry of Health. Following the provincial election in the spring of 1999, the Minister's title and that of her department were renamed as follows: *Minister of Health and Long-Term Care* and the *Ministry of Health and Long-Term Care*. For consistency, the title Minister of Health is used throughout this report and the acronym MOHLTC to describe the Ministry.

Health Science Centre was part of a community being reviewed a further set of criteria, including the anticipated impact of change on medical and health professional education and clinical research, was considered.

### Creating a vision of the future health system

The absence of a vision of what the future health system in Ontario would (and should) look like at the end of restructuring was a key concern of Commissioners from their inaugural meeting. The Commission felt strongly that it was important to create a vision that would position its work related to directing changes to hospitals as *one* of the components of a broader health system reform agenda. The task of creating a vision was believed to be important to:

- Ensure that hospital restructuring decisions made sense in relation to an overall plan
- Clarify the reasons for change and the expected outcome of reforms, and
- Provide a context for generating public and provider feedback

In creating this vision, the HSRC was challenged to: focus on rebalancing the system, put more emphasis on the balance of resources needed along the entire continuum of care, better integrate and co-ordinate care, and create a patient-centred (as opposed to hospital-centred) system.

The first draft vision statement was released by the HSRC in January 1997. It described Ontario's future health system as a "series of inter-connected, integrated health systems and integrated academic health systems." These systems, composed of groups of hospital and community health organizations, would each be responsible for the health of a defined population.

The vision document also described the essential building blocks of the future health system, including, among others: shared goals, priorities and performance standards among the various health sectors; improved knowledge upon which administrative and clinical decisions are made; a focus on population health as well as individual health; a shared information system with up-to-date and accurate information; a reformed primary care system; incentives and diversity in encouraging strategic alliances; shared accountability; and envelope funding to allow organizations to meet the total health needs of a defined population.

The Commission invited responses to the draft vision statement — in effect its working hypothesis. Over 140 submissions were received in response to the draft vision with the majority of feedback from provider groups and provincial health care organizations. The HSRC's revised, final vision statement for Ontario's future health system was developed in January 2000.

### Analyzing and evaluating restructuring options

The HSRC had the authority to close and merge hospitals and to move clinical activity between hospitals. However, authority over funding of hospitals remained with the Minister of Health.

The Commission's reports, *Directions*, and advice to the Minister were developed based on a framework of analysis that included the following:

- Establishing performance benchmarks for acute in-patient care
- Applying mental health in-patient benchmarks
- Applying benchmarks for sub-acute care, complex continuing care and rehabilitation
- Applying projections for growth and aging of the population
- Deciding about facilities to be closed or amalgamated
- Governance

- Adequacy of reinvestment in other health care sectors (e.g., long-term care, home care)
- Infrastructure investment and other one-time costs associated with restructuring

The principal points of deliberation included: configuration of hospital services based on determining capacity requirements for acute in-patient, sub-acute, rehabilitation, mental health and complex continuing care beds and a review of potential siting options; development of cost/savings methodologies; review of governance models to lead the restructured system; and reinvestments required to support the new system.

One of the immediate outcomes of urban hospital restructuring has been to achieve significant consolidation, initially of governance and senior management. The first step of achieving a restructured governance structure holds the greatest potential for consolidating administrative and support services and clinical programs. In the long term, the HSRC expects there will be more opportunity to reassign resources to patient care through administrative and support services efficiencies.

## Reinvestments

The HSRC conducted its work on the basis of the Government's policy commitment to at least maintain its $17 billion plus level of annual health care funding (1996-97 provincial health expenditure). In other words, restructuring would proceed in a financially stable system. This provided the assurance of opportunities to reinvest in alternative (to hospital) services offering comparable or improved outcomes at lower costs, and/or to expand services that would address gaps or shortfalls in the current system.

In July 1997 the HSRC released a draft of its proposed planning guidelines in a document titled *Rebuilding Ontario's Health System: interim planning guidelines and implementation strategies*. This discussion paper provided an overview of a series of HSRC projects to develop planning guidelines for home care, long-term care, mental health, rehabilitation and sub-acute care. These guidelines would be used to determine future capacity and service levels and/or the reinvestments necessary to support a restructured health system.

The HSRC was surprised and dismayed to discover at the outset the paucity of good data and information. While Ontario has a comprehensive and reliable database on hospital in-patients, the same does not hold true for ambulatory patients or for the services provided in and by other components of the system (primary care, rehabilitation, home care, etc). This was a principal obstacle in developing sensible and objective guidelines needed to advise government on appropriate reinvestments in alternatives to hospital services.

The HSRC's final recommendations offering advice to the Minister on guidelines for reinvestment were released in the April 1998 paper, *Change and Transition: planning guidelines and implementation strategies for home care, long-term care, mental health, rehabilitation and sub-acute care*. The HSRC's advice to government on implementing the proposed guidelines was also intended to promote greater integration and interdependency between and among the sectors.

On April 28, 1998 the government announced it would reinvest $2 billion in home care and facility based long-term care. This commitment began to ease the apprehension of the Commission and the health sector over whether reinvestment would, in fact, occur. However, at the conclusion of its mandate the HSRC remains concerned that continued slowness in the pace of reinvestments will jeopardize successful restructuring and risk the loss or diminish the gains made toward the creation of a genuine health system.

| [redacted] OF ANNUAL SAVINGS AND ANNUAL REINVESTMENTS RECOMMENDED BY THE HSRC | |
|---|---|
| **Savings*** | **Reinvestments** |
| Acute care:<br>$800 million in annualized savings identified | Care in other settings:<br>$165 million in home care<br>$110 million for hospital sub-acute care<br>$110 million for hospital rehabilitation |
| Long-term care:<br>$130 million in chronic care savings identified | Long-term care:<br>$390 million for LTC beds<br>$290 million for LTC places |
| Mental health:<br>$100 million in savings identified for re-allocation into community/support programs | Mental health:<br>$90 million in community mental health<br>$10 million for hospital care |
| Total: $1.1 billion | Total: $1.2 billion |
| * urban hospitals only | |

Throughout its mandate, the HSRC has also been concerned about capital investment to support restructuring of the hospital sector. On a number of occasions, the HSRC urged the MOHLTC to expedite the release of decisions on capital investments.

The HSRC recommended a total of approximately $2.1 billion in capital development projects involving 96 hospital sites. Injection of this money would represent the largest single investment in new and renovated buildings and equipment in Ontario's history. As of February 2000, the Ontario Government had approved 58 projects valued at $1.6 billion on 40 sites in support of restructuring. Some of the 58 projects are for "headstart" projects. That is, pieces of larger projects that are proceeding ahead of the main contract to accommodate, for example, the expansion of emergency departments in advance of the 'main' building.

The need for capital reinvestment in other sectors of the health system has also been acknowledged by the HSRC as critical to the restructuring process. In addition, the HSRC noted there would be a series of one-time costs associated with hospital restructuring including such things as: purchase of capital equipment; demolition and decommissioning costs; and labour adjustment costs. While hospital foundations and working capital funds may be able to support a portion of these expenses, the Commission recommended that government contribute a portion as well. In 1997-98, the Province announced that it would provide support for hospitals (that were eligible) for reimbursement of these restructuring expenses.

## Mental health reform

The HSRC advocated three planks in mental health reform:

1. That an envelope of funds exclusively for mental health services be created;
2. That this envelope be protected (and expanded) and that resources 'saved' from institutional restructuring be reallocated to community and other mental health services; and
3. That community supports be in place prior to closure of beds in provincial psychiatric hospitals (PPHs).

Throughout its mandate, the HSRC repeatedly recommended the establishment of regional Mental Health Agencies (later renamed Mental Health Implementation Task Forces). This concept was introduced in the HSRC's first restructuring report issued in Thunder Bay in October 1996. These interim/transitional groups were envisioned as devolved decision-making organizations responsible for expediting provincial divestment of PPHs and ensuring reinvestment in the mental health sector in the community/district/region concerned.

The HSRC submitted formal advice to the Minister of Health in February 1999 to heighten its awareness of the slow progress in mental health reform. The document, *Advice to the Minister of Health on Building a Community Mental Health System in Ontario*, outlined strategies to ensure appropriate systems are in place and monitored when PPHs divest their responsibilities to other community organizations. On March 12, 1999, the Minister of Health formally accepted the HSRC's advice and began to establish regional Mental Health Implementation Task Forces. But to this date only two have been created – one in Northeastern and one in Northwestern Ontario.

As the HSRC closes its doors in March 2000, the slow pace of divesting provincial ownership and management of PPHs and the realignment of services associated with this process continues to be a major barrier to expediting restructuring in those communities where the Commission advised the Minister to divest PPH operations and management.

## Review of rural/northern hospitals

Hospitals in rural and small northern communities face the particular challenges of thinly populated and isolated areas. They include: long distances to health care services; low patient volumes that frustrate the development of a critical mass of programs and services; and recruitment and retention of physicians and other health professionals. Given these challenges, the HSRC maintained from the outset that the issue of accessibility was paramount to the restructuring process in rural/northern communities.

The *Rural and Northern Health Care Framework* was issued by the MOHLTC in June 1997. The framework stated broad guidelines for restructuring rural and northern hospitals within *health care networks* that would help achieve 24-hour access to services. The first priority was to develop hospital networks. The longer-term goal was to establish a series of health care networks that would involve community-based providers as well as hospitals. The framework guided the HSRC in its process and review of rural/northern hospitals.

The HSRC's review of rural and northern Ontario hospitals led to its recommendations for the formation of 18 new hospital networks, made up of a total of 100 hospitals. The Commission's final advice on the networks was delivered to the Minister of Health in February 2000. The advice addressed three areas: confirmation of network membership (total of 18 networks); strategies and policy mechanisms to assist hospitals in establishing the networks; and recommendations on organizational

structures for each network, as well as advice on sizing and siting of acute and non-acute hospital services.

### Human resources planning and labour adjustment

In a number of communities, the HSRC appointed facilitators to assist hospitals and employee groups in developing human resources plan(s) to aid in labour adjustment. The facilitators brought the parties together to develop city-wide (or region-wide) plans for labour adjustment as well as plans to address issues specific to a small number of hospitals and/or that the parties agreed needed attention locally.

### Province-wide initiatives

The HSRC identified and acted on a number of issues needing additional investigation or alternative approaches. These included:

- Appointment of a medical human resources fact-finding team to recommend ways to address physician human resource adjustment issues arising from restructuring. A key accomplishment of the fact-finders was recognition of the need for a principle-based process to ensure such adjustments were made in a fair and equitable manner that protected quality patient care;

- Establishment of a Provincial Paediatric Task Force (PPTF) to assess the potential for program consolidation and co-ordination of service delivery for low volume, highly specialized tertiary and quaternary paediatric cases, such as specialized surgery and transplantation;

- Establishment of a provincial Women's Health Council. On December 8, 1998, the Minister of Health and Minister Responsible for Women's Issues acted on the HSRC's advice and confirmed the creation of the Women's Health Council.

- Review of availability of cancer services in certain regions;

- Review of availability of cardiac services in certain regions.

### Legal challenges

There were numerous legal challenges to the HSRC's *Directions*. In all cases but one which have been heard and judgements have been made to date, the courts have ruled in favor of the Commission. At the time the Commission closed (March 28, 2000), one legal case was pending.

### Changing hospital landscape

In total, 22 communities received HSRC *Directions*. Once hospital restructuring in Ontario is complete, the health care landscape will be different. Some of the characteristics of the new environment include:

- Amalgamation of several hospitals to form new, fewer but larger health care organizations
- Closure of 31 public hospitals, six private and six provincial psychiatric hospital (PPH) sites
- Takeover of four hospitals by other hospital corporations
- Creation of several joint committees to provide shared governance to multiple organizations
- Creation of 18 rural/northern hospital networks
- Establishment of a variety of regional and provincial networks (including child health networks in Ottawa, Toronto and London, rehabilitation networks and a French language services network in Ottawa)

Implementing these reforms, and reinvesting in the system to support their execution, will result in:

- Removal of excess hospital bed capacity
- Better use of capital resources

- Rationalized hospital programs and services
- Multi-institutional organizations with a single governance structure
- A more appropriate balance of institutional and community-based care
- Increased hospital capacity with greater efficiencies, resources, and increased emergency room and ambulatory capacities
- Expanded home care and long-term care, enabling hospitals to focus on the accommodation of acutely ill patients
- Incorporation of a population needs approach in developing planning guidelines for reinvestment
- New resources and funds
- Pinpointing data needs and limitations
- New networks focused on building a better continuum of care
- Determining the need for new funding tools and mechanisms to support future health system development

In reflecting on its work, the HSRC observed the following regarding the changing hospital/health care landscape:

- There is an informed audience across the province that recognizes health system change is essential, and that difficult decisions must be made
- Many communities have the desire and willingness to embrace change to prepare better for the future. However, people inherently resist change and therefore don't easily or quickly respond to it
- Turf protection continues to be prevalent in the health system
- Restructuring means a redesign of the health system and requires people, government and health care organizations to change their attitudes, be open to new approaches and alliances, and adapt to new circumstances
- Some hospitals have taken up the challenge of restructuring; others have resisted
- As a result of restructuring, rebalancing of health services through reinvestment in community-based services such as home care and long-term care, is essential
- Data and information to determine levels of health services are almost non-existent and must be enhanced
- The province needs strong, consistent leadership to steer health system reform

## Building a health services system: achieving the vision

Between 1996-1999 the HSRC worked primarily on restructuring the hospital sector. During the last year of its mandate (1999-2000) the Commission focused on ways to ensure restructuring extends to other parts of the 'system' and is monitored and evaluated on an ongoing basis. It also provided specific advice to the Minister on future system restructuring, including the vision and key issues that require attention to achieve better co-ordination and continuity of care to build a truly effective health system in Ontario.

As part of this work, the HSRC initiated a series of round table discussions with key stakeholder groups and met with a small international panel of experts to explore issues for consideration in future health system reform. The round table groups identified five key priority issues:

- State and communicate a vision of health reform – leadership is vital!
- Eliminate silos and enhance integration
- Make primary care reform the foundation of future reforms and the connector to the rest of the system
- Invest in an accessible, shared information management system
- Align incentives among health care providers and consumers to improve accountability at all levels, and to stimulate 'systems' thinking and behavior.

The HSRC developed a strategic framework for improving the system of health services ('systemization') and the health of the population through development of a more effective and integrated health system. This framework focused on improved quality, access and affordability; improved co-ordination and continuity of care; and, rebalancing of the various components of the health system. Key strategies in which the HSRC provided advice to the Minister related to:

- A strategy for health information management
- A strategy for primary health care reform
- A series of projects within Ontario communities that are actively working on health services integration
- A framework and process for assessing improvements in the performance of the health services system
- Advice on the role and responsibilities of government as 'governors' of the restructured health system.

## Lessons learned: looking back, looking forward

The HSRC reviewed its own performance in a series of interviews held in November 1999 with senior staff, senior government/MOHLTC representatives, selected hospital representatives, and key stakeholders who participated in/were impacted by restructuring.

Respondents agreed the HSRC had been a necessary entity to mobilize restructuring. It was agreed that it had executed its mandate well, and also that its "sunset" was appropriate. However, it was agreed that much remains to be done, either by the MOHLTC alone and/or with an advisory body having responsibility to implement health services restructuring, or, through the establishment of an independent arms-length body delegated with partial or full authority to carry out these tasks.

# Section I: Background

## Mandate and Authority
## Membership
## The Environment
## Approach and Process
## Decision-Making Criteria
## Public Relations Strategy

HSRC

# SECTION I: BACKGROUND

## Mandate and Authority

In March 1996 the Ontario Legislature created the *Health Services Restructuring Commission* ("the Commission" or "HSRC") primarily to restructure hospitals in Ontario. Established for a four-year term[4] by statute as an arms-length body from government, the HSRC was empowered to direct hospitals to amalgamate, transfer or accept programs, change their volumes, cease to operate or make any other changes considered to be in the public interest.

The Commission's formal mandate was to undertake three broad tasks:

1. To make binding decisions on the restructuring of hospitals
2. To make recommendations on the restructuring of sectors or other elements of the health services system, including advice about reinvestment needed to restructure hospitals and enhance other health services
3. To foster the creation of a genuine, integrated, co-ordinated health services system.

The mandate of the HSRC and the scope of authority granted to it were unprecedented in Ontario's history. The HSRC officially sunsetted on March 28, 2000.

## Membership

On February 28, 1996 Duncan Sinclair, the then Dean of Medicine at Queen's University, was appointed Chair of the Health Services Restructuring Commission.

In March 1996 the following six additional individuals were appointed as members to the HSRC: Shelly Jamieson, Maureen Law, George Lund, Hart MacDougall, Dan Ross, and Don Thornton. Appointments were made through Order-In-Council. At the same time, Dr. David Naylor was appointed by the Chair as Special Advisor to the HSRC, and served as an ex-officio member of the Commission until March 1998. In his role as Special Advisor, Dr. Naylor provided advice on the development of processes and methodologies that were developed by the HSRC staff and legal advisors. He also served as a sounding board for the HSRC in reviewing restructuring options throughout the first year and a half of the Commission's mandate.

As the work of the HSRC progressed, the Chair formally requested that the government appoint additional members to the Commission to help deal with the increasing work load, growing expectations regarding advice around reinvestments and other issues, and to pick up the pace of decision-making related to restructuring in urban communities. Subsequently, five more members were appointed to the Commission: Doug Lawson in 1996, Harri

[4] On November 30, 1999, a Bill was introduced in the provincial legislature that provided for amendments to the Public Hospitals Act to ensure that the powers of the Minister to issue *Directions* with respect to the operation of hospitals under Section 6 of the Act were not repealed on March 28, 2000. The Bill allows the Minister to continue making such *Directions* but only to hospitals that have been issued a previous *Direction* or *draft Direction*, that have received a *Notice of Intention to Issue a Direction* or a draft of such a *Notice* or that are established as a result of a *Direction* or *draft Direction*. The Bill requires that a review of the powers contained in Section 6 be undertaken on or before January 1, 2005 and allows the Minister to make recommendations regarding those powers to the Lieutenant Governor in Council after the review. The Bill received Royal Assent on December 14, 1999.

Jansson, Muriel Parent and Rob Williams in April 1997, and Ruth Gallop in the Fall of 1998. The biographies for each of the commissioners are included in Appendix A.

The Commission also had the opportunity to call upon the expertise of many industry leaders, practitioners and consultants as it developed its reports, bringing an unparalleled wealth of knowledge and experience to its work and reports.

## The Environment

The HSRC was established on the heels of two announcements (December 1995) by the provincial government:

- That the health system would be stable financially throughout the subsequent four years. The operating budget of the MOHLTC was guaranteed to remain not less than its 1995-96 level of approximately $17.4 billion.
- To reduce hospital budgets by 18 per cent over a three-year period (5% in 1995-96; 6% in 1996-97; and, 7% in 1997-98).

The latter announcement gave rise to cynicism about restructuring within the hospital sector and created the strong perception that the HSRC was simply an agent of the government mandated to "manage" hospital budget reductions. It is important to note that during the early days of the HSRC's existence, Ontario's health care environment was also characterized by a number of other features (see Figure I-1).

**Figure I-1: Characteristics of the environment during 'early days' of HSRC mandate**

| | |
|---|---|
| **Government Features** | • Announced reduction in hospital revenues by 18 per cent over three years 1995-96 to 1997-98<br>• Continuing lack of vision and leadership of the health system<br>• Discontinuity between decisions of the HSRC and activities/action by the MOHLTC |
| **Local/Public Features** | • Perception of 'insensitivity' of the HSRC to local circumstances<br>• Concern about "change", closure of local hospitals and the status of the work and recommendations put forward by District Health Councils (DHCs) regarding local hospital restructuring initiatives<br>• Public concern about the health system but, satisfaction for the most part, with individual experiences with the system<br>• Commonly-held perception that health reform (including hospital restructuring) is being driven solely by financial considerations — saving public money — and is being undertaken by government on its own behalf, not that of the population/electorate |
| **Political Features** | • Difficulty for provincial politicians to support the work of the HSRC<br>• Need for the HSRC to move as quickly as possible (implementation time horizon and timing of next provincial election)<br>• Arms-length relationship of the government and the MOHLTC to the HSRC |

| Familiar Features | |
|---|---|
| | • Reactions of health provider interests and their supporters that health services will suffer as a result of HSRC decisions<br>• Excess hospital bed capacity due to technological and practice innovation<br>• Inability of hospital providers to deal voluntarily with excess capacity<br>• At least five years of decline in employment in hospitals and no increases in salaries of hospital workers (as a result of constrained operating budgets from government)<br>• Strained relationships between physicians (represented by the Ontario Medical Association, OMA) and the government<br>• Strained relationships between physician members and the OMA<br>• Mandated reduction in medical student enrollment and post-graduate training<br>• Substitution of ambulatory services for in-patient services<br>• Restructuring of the Ontario Hospital Association (OHA) under new leadership<br>• Support for restructuring by health sector opinion leaders<br>• Absence of accountability relationship between providers and payers |

## Approach and Process

The HSRC held its first meeting on April 24, 1996. At that meeting, agreement was reached on the following approach to fulfill the HSRC's mandate:

1. Acceptance of the prime mandate of the HSRC to facilitate hospital restructuring. The HSRC would have preferred, however, to deal initially with restructuring of the primary care and community services system as a first order of business, rather than beginning with the task of restructuring hospitals. In other words, it would have made more sense to begin restructuring (creation) of a genuine health services system at its front end, rather than with the "institutions of last resort".

2. Efforts to restructure will begin with a focus on hospitals in major municipalities in Ontario (i.e., urban communities as well as nearby hospitals in surrounding communities) given that most of the hospital resource base is concentrated in eight communities.[5]

3. Following a review of 'urban' hospitals, the HSRC will focus on restructuring hospitals elsewhere.

4. The mandate of restructuring hospitals should be addressed within the broader context of health *system* reform so that the public and providers can begin to understand the need for restructuring within a broader 'vision' of what a restructured health services system should look like.

5. Although the HSRC's mandate is for a four-year term, the 'window of opportunity' to make the tough decisions required to restructure the system is closer to two years given the political realities for any government in power. Thus, a limiting factor for the HSRC is that its work plan and time frames for restructuring hospitals must be accomplished within a compressed time period.

[5] The eight communities were Hamilton, Kingston, London, Ottawa, Sudbury, Thunder Bay, Toronto, and Windsor. These communities also provided the greatest potential for savings. Various restructuring plans affecting most of these communities were completed prior to the establishment of the HSRC. These plans addressed potential options for restructuring. Although various methodologies were employed, most plans were comparable. Their focus was on improving clinical efficiency and effectiveness, reducing excess capacity in the system, and eliminating redundant overhead and administrative costs to the system.

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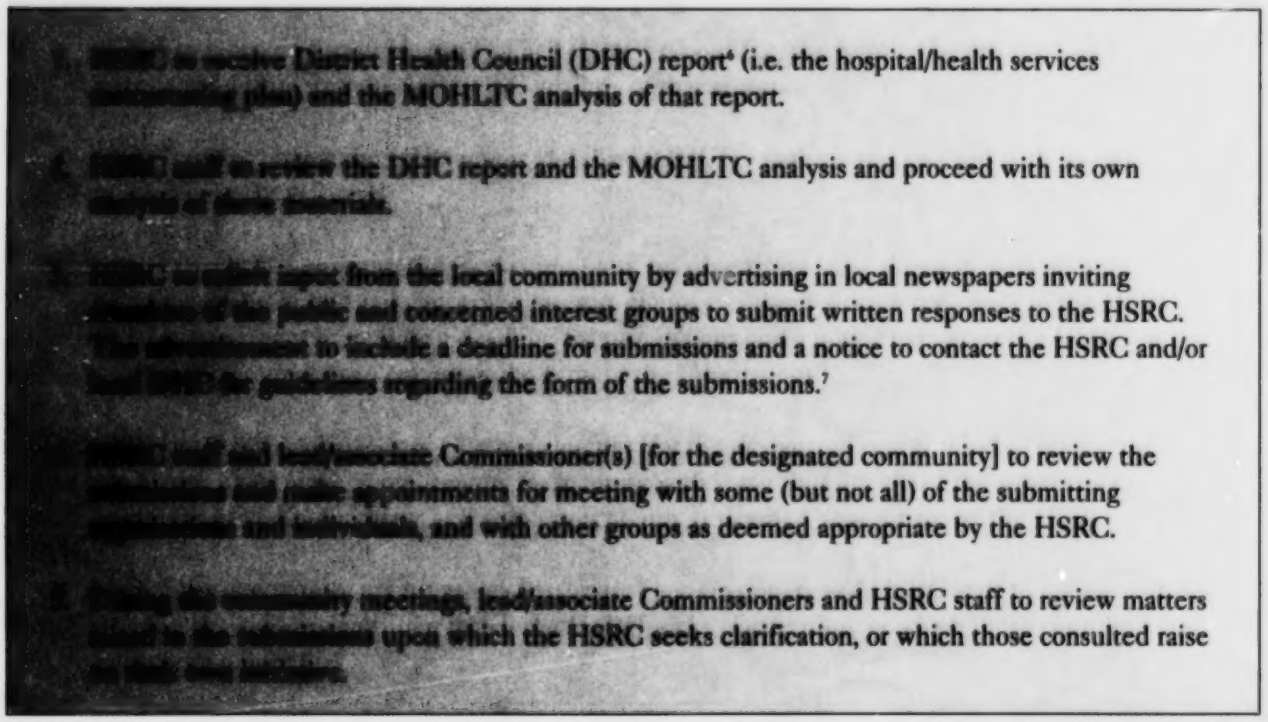
6. Lead and accompanying commissioners will be assigned to individual communities to be involved at key points throughout the analysis and development of options, and to oversee the work of the HSRC staff.

7. The approach to the HSRC's analysis of hospitals in individual communities will follow a standard process. The process will be articulated to all concerned parties (including the general public) which will allow for the input of perspectives from the general community from the outset. The approach must be transparent and participatory in nature.

8. A media and/or public relations strategy will be an important component of "doing the job properly" given the strong attachment and loyalty of communities to their hospital(s).

Early in its mandate, agreement was also reached on a framework to guide the development of options and assist the HSRC in evaluating them. The core elements of the framework are outlined in Figure I-2.

**Figure I-2: Framework for review of hospital restructuring options**


District Health Council (DHC) report[6] (i.e. the hospital/health services
MOHLTC analysis of that report.
DHC report and the MOHLTC analysis and proceed with its own
the local community by advertising in local newspapers inviting
groups to submit written responses to the HSRC.
a deadline for submissions and a notice to contact the HSRC and/or
regarding the form of the submissions.[7]
Commissioner(s) [for the designated community] to review the
for meeting with some (but not all) of the submitting
other groups as deemed appropriate by the HSRC.
meetings, lead/associate Commissioners and HSRC staff to review matters
upon which the HSRC seeks clarification, or which those consulted raise

[6] It is important to note that the availability and/or quality of the DHC reports varied greatly. For example, not all DHCs undertook and/or completed reports regarding local hospital restructuring. In other cases, DHCs initiated local studies but were unable to reach consensus at the community level regarding preferred restructuring options.

[7] The HSRC developed general guidelines for written submissions. There was also agreement that the HSRC would not undertake full consultation at the community level given the extensive consultations already carried out by DHCs as part of their process in developing local restructuring reports and recommendations.

6. Following the community meetings, HSRC staff to complete their analysis of all the information received and proceed with development of restructuring options for review and debate by the full Commission.

7. Options to determine the number and type of hospital sites in a community building on "local solutions" and assessed against three primary decision-making criteria: quality, accessibility, and affordability (see discussion below).

8. HSRC to consider the HSRC staff's analysis and options and make a preliminary determination of the issues that are relevant to hospital restructuring, the substance of the Section 6(5) notice to the affected hospitals, and the reasons why the HSRC should make particular decisions.

9. Following passing of a formal motion by the HSRC, formal *Notices of Intention to Issue Directions* to be issued and delivered to the affected institutions, together with reasons for the decisions.

10. The Section 6(5) notice to identify the specific *Directions* that the HSRC intends to issue and to invite representations from any hospital that is the subject of a *direction* and any other person or organisation, in accordance with the guidelines issued by the HSRC.

11. After the HSRC has considered the representations and undertaken additional analysis/ investigation as required, a formal motion to be passed and final *Directions* issued.

12. Each direction to include the text of a formal motion that the HSRC will direct be enacted by the hospital board. Such motion causes implementation of the HSRC's *Directions*.

13. If, within a reasonable time, the hospital board has not passed the required resolution, the HSRC to notify the Minister of Health and recommend whether or not a supervisor should be appointed under Sec. 9 of the Public Hospitals Act. The supervisor would then take all necessary steps to implement the HSRC *Directions* under Sec.6(5).

6. Lead and accompanying commissioners will be assigned to individual communities to be involved at key points throughout the analysis and development of options, and to oversee the work of the HSRC staff.

7. The approach to the HSRC's analysis of hospitals in individual communities will follow a standard process. The process will be articulated to all concerned parties (including the general public) which will allow for the input of perspectives from the general community from the outset. The approach must be transparent and participatory in nature.

8. A media and/or public relations strategy will be an important component of "doing the job properly" given the strong attachment and loyalty of communities to their hospital(s).

Early in its mandate, agreement was also reached on a framework to guide the development of options and assist the HSRC in evaluating them. The core elements of the framework are outlined in Figure I-2.

**Figure I-2: Framework for review of hospital restructuring options**

1. **HSRC to receive District Health Council (DHC) report[*] (i.e. the hospital/health services restructuring plan) and the MOHLTC analysis of that report.**

2. **HSRC staff to review the DHC report and the MOHLTC analysis and proceed with its own analysis of these materials.**

3. **HSRC to solicit input from the local community by advertising in local newspapers inviting members of the public and concerned interest groups to submit written responses to the HSRC. The advertisement to include a deadline for submissions and a notice to contact the HSRC and/or local DHC for guidelines regarding the form of the submissions.[†]**

4. **HSRC staff and lead/associate Commissioner(s) [for the designated community] to review the submissions and make appointments for meeting with some (but not all) of the submitting organisations and individuals, and with other groups as deemed appropriate by the HSRC.**

5. **During the community meetings, lead/associate Commissioners and HSRC staff to review matters raised in the submissions upon which the HSRC seeks clarification, or which those consulted raise on their own initiative.**

[*] It is important to note that the availability and/or quality of the DHC reports varied greatly. For example, not all DHCs undertook and/or completed reports regarding local hospital restructuring. In other cases, DHCs initiated local studies but were unable to reach consensus at the community level regarding preferred restructuring options.

[†] The HSRC developed general guidelines for written submissions. There was also agreement that the HSRC would not undertake full consultation at the community level given the extensive consultations already carried out by DHCs as part of their process in developing local restructuring reports and recommendations.

6. Following the community meetings, HSRC staff to complete their analysis of all the information received and proceed with development of restructuring options for review and debate by the full Commission.

7. Options to determine the number and type of hospital sites in a community building on "local solutions" and assessed against three primary decision-making criteria: quality, accessibility, and affordability (see discussion below).

8. HSRC to consider the HSRC staff's analysis and options and make a preliminary determination of the issues that are relevant to hospital restructuring, the substance of the Section 6(5) notice to the affected hospitals, and the reasons why the HSRC should make particular decisions.

9. Following passing of a formal motion by the HSRC, formal *Notices of Intention to Issue Directions* to be issued and delivered to the affected institutions, together with reasons for the decisions.

10. The Section 6(5) notice to identify the specific *Directions* that the HSRC intends to issue and to invite representations from any hospital that is the subject of a *direction* and any other person or organisation, in accordance with the guidelines issued by the HSRC.

11. After the HSRC has considered the representations and undertaken additional analysis/ investigation as required, a formal motion to be passed and final *Directions* issued.

12. Each direction to include the text of a formal motion that the HSRC will direct be enacted by the hospital board. Such motion causes implementation of the HSRC's *Directions*.

13. If, within a reasonable time, the hospital board has not passed the required resolution, the HSRC to notify the Minister of Health and recommend whether or not a supervisor should be appointed under Sec. 9 of the Public Hospitals Act. The supervisor would then take all necessary steps to implement the HSRC *Directions* under Sec.6(5).

## Decision-Making Criteria

The Commission's assessment of all of the restructuring options and its decisions regarding the 'preferred' option were based on the three evaluative criteria of quality, accessibility and affordability, defined as outlined in Figure I-3.

**Figure I-3: Evaluative decision-making criteria**

| Evaluative Criteria | Performance Measures/ Indicator(s) | Definition/Description |
|---|---|---|
| **QUALITY** | | **To ensure that the services to which people have access are of the highest possible quality defined in terms of *critical mass* and *clinical coherence.*** |
| | **Critical mass** | Level of program and clinical activity that maximizes efficiency and effectiveness of service delivery in terms of :<br>- patient volumes<br>- maximizing effective outcomes<br>- concentration of specialized skills and expertise<br>- provision of appropriate levels of staffing for recruitment and retention to support quality clinical outcomes, and<br>- minimizing overhead and indirect expenses. |
| | **Clinical coherence** | Clinical relationships between different programs and services and the relative benefits of locating programs in conjunction with, or close to, related programs. Some considerations in assessing clinical coherence were:<br>- maximizing continuum of patient care requirements for a single episode of care<br>- providing for a co-ordinated response to needs with a variety of related services<br>- minimizing duplication, and<br>- reducing patient transfers between sites for related services. |

| [illegible]tive Criteria | Performance Measures/ Indicator(s) | Definition/Description |
|---|---|---|
| **[illegible]SSIBILITY** | | **To maintain and, where possible, enhance people's access to hospital-based services and alternative community-based services (home care, long-term care, etc.).** |
| | Ability to meet the needs/service requirements of the population served | Examination of population characteristics/needs and service requirements to locate the hospital services near the population being served. |
| | Access and proximity of hospital programs/services | Examination of the driving distances to the hospitals and the location of the population they serve.<br><br>Location of hospital services near the population served. |
| | Patient transfers | Limit in the number of transfers between facilities of patients for hospital services. |
| **AFFORDABILITY** | | **To ensure that hospital-based services are provided efficiently and effectively and that the highest proportion of funds possible are spent on direct patient services. Affordability was evaluated based on the extent to which each option met the specified criteria.** |
| | Contribution to clinical efficiency | Extent to which each option achieves clinical efficiencies derived from admission management, reduced ALOS and appropriate placement of ALC patients.[8] |
| | Restructuring savings | Level of productivity and efficiency achieved by each option. |
| | Administrative efficiencies | Level to which administrative savings can be achieved by each option. |

[8] Some of the efficiencies, particularly in acute ALOS reduction, depend on the availability of and access to complementary services in in-patient rehabilitation and mental health services.

| [illegible]ative Criteria | Performance Measures/ Indicator(s) | Definition/Description |
|---|---|---|
| | Economies of scale | Level to which economies of scale can be achieved by each option. |
| | Support service consolidation | Level to which consolidation of support services (including materials management, food services and clinical laboratories) can be achieved by each option. |
| | Capital & restructuring implementation costs | Level to which capital costs and restructuring implementation costs can be minimized by each option. |
| | Support for reinvestment | Support for reinvestment of funding in other areas of the local and regional health system. |

Where an Academic Health Science Centre (AHSC) was reviewed a further set of criteria taking into account academic considerations were employed. These included:

- **Medical and health education:** Effect/impact on the ability of the medical school and/or faculty of health sciences and the affiliated hospitals to conduct its education mandate.

- **Clinical research:** Effect/impact on the nature and scope of clinical research activities associated with the medical school and/or the faculty of health sciences and the affiliated hospitals.

## Public Relations Strategy

There were a number of issues related to public perception of the restructuring effort that were evident at the outset of the HSRC's work. For example:

- **The public was not aware of the "big picture"**
  - *Why was hospital restructuring being undertaken?*
  - *What will the restructured system look like?*
  - *What will a seamless, integrated system look like?*

- **The public was overloaded with "bad news"**
  - *Strong perceptions that changes to the health system were equated with cuts, and would mean a "loss" to the community or health care generally*
  - *The tough parts of decisions made headlines while the proposed reinvestments were buried*
  - *The HSRC had an opportunity to clarify the need for change and put the agenda into perspective*

- **Fundamental concerns pervaded the environment of change**
  - *Job loss, labour force adjustment, management of long-term care and mental health services*
  - *Short time frame for complex change*
  - *Fear intensified the resistance to change.*

The HSRC realized it had to address and correct these misconceptions head on. It began by communicating the following key messages to members of the public and those in the health sector as it carried out its review of hospitals:

- *The status quo cannot be preserved.*

- *The Commission will use local planning processes as its starting point (primarily those conducted by the DHCs), but also must ensure that its decisions meet the evolving needs of Ontarians (e.g., by taking into consideration population growth and other changes), changing patterns and practices of health care delivery, and the fiscal realities of the mid-1990s and beyond.*

- *The Commission's goal is to build a better health system. The mandate is not about cutting costs. Its concern is to ensure the continuation of high quality and accessible health services, rather than the preservation of bricks and mortar. The intent is to enhance rather than diminish a full basket of services for Ontario residents.*

- *All money 'saved' through hospital restructuring should be reinvested in other parts of the health sector. Furthermore, in accordance with (and in support of) government policy, any money 'saved' through the restructuring of mental health services must be reinvested exclusively back into the mental health system.*

- *The Commission is working to preserve Ontario's health services and to shape them into an integrated 'system' that provides high quality health care that is affordable and accessible.*

- *The HSRC will act as an independent, non-partisan agency arms-length from government working with local hospitals, DHCs and key stakeholders in the field to ensure that local hospital restructuring initiatives are appropriate to Ontario's current health and fiscal realities. It will focus on preserving the health system in the long term. It also wanted to demonstrate, through its approach and processes, that restructuring is being implemented fairly and equitably across the province.*

The HSRC was determined — to the extent possible — to communicate directly with Ontarians through news media and other communication vehicles. Commissioners were open to interviews with the media and meetings with editorial boards and key reporters were actively sought. The Chair, Commissioners, and Commission staff, in total, gave *thousands* of interviews. In addition, (as noted earlier) the public process that the HSRC followed for hospital restructuring included a call for written submissions in each community visited, face-to-face meetings with key stakeholders,

release of *Notices of Intention to Issue Directions*, a 30-day appeal period following the issuing of *Notices*, and then the release of the final *Directions*. The HSRC began its visit to each of the communities with a formal press conference involving local media. Following the release of the *Notices* and *Directions*, the lead and associate commissioners for each community were proactive in seeking to meet with members of the local media and political leaders to discuss the HSRC's decisions and address questions.

Some hospital boards were aggressive in their efforts to discredit the HSRC with the local media. This activity demonstrated their resistance to change. These same boards, in several cases, used considerable funds to launch legal challenges thereby generating more headlines.

Following release of *Directions* in the first few communities visited, it was evident the HSRC would require a more direct approach in communicating its key messages to explain, in a factual manner, the decisions included in the HSRC *Directions*. As a result, the HSRC purchased full-page advertising space in local newspapers the day following release of its *Notices* and again upon release of its *Directions* in individual communities. These ads focused on articulating the facts related to the HSRC's decisions and the overall reasons for them. The ads also invited questions and comment from the community and offered more information upon request about the work of the Commission. It was the view of the Commissioners that public interest in our health system warranted the ads to ensure that the HSRC's work was transparent and the public was informed. Despite the ad's prominence, there was very little response from the public in terms of submissions or requests.

Another key component of the HSRC's public relations strategy included speaking engagements by Commissioners at provincial conferences, meetings and workshops. The Chair of the Commission spoke frequently throughout the HSRC's four-year mandate about the need for restructuring to support future stability in the 'system', the work schedule and processes related to the Commission's work, and the 'big picture' of health reform.

The HSRC also approached all three political caucuses and their leaders (Liberals, New Democrats, Progressive Conservatives) early in its mandate and extended an invitation to meet with members of each caucus to talk about the HSRC's work. At the end of its mandate, the HSRC again extended invitations to all parties to return to discuss the 'results' of its work as well as next steps that need to be taken to build an integrated, pro.. cial health services system.

The barrage of criticism directed at the HSRC through the media underlines how difficult health restructuring and re-balancing is to undertake. The merit of an independent and arms-length Commission was never more obvious than during these media melees.

# IMPORTANT INFORMATION ABOUT BUILDING A BETTER HEALTH SYSTEM IN SAULT STE. MARIE.

## Why are changes being made?

Ontario's health system must change to keep up with peoples' needs. That is why the Ontario Government created a volunteer body called the Health Services Restructuring Commission.

We are doctors, nurses, health care educators, former hospital board members and other experts. We are making difficult decisions to improve Ontario's health services for present and future generations.

We must spend health dollars more effectively. We are not cutting overall health expenditures. The first phase of our work is to ensure hospitals are better able to meet the future needs of Ontario. In phase two, we will identify ways that all sectors of the health system can work together better.

Ontario is spending $18 billion in public funds on health care this year. We are finding ways to get the best possible health system that our tax dollars can buy.

## Preserving the best health care

Ontario's health care services are second to none. We want to keep it that way. But the population, technology and knowledge about health care have changed. An increasing number of seniors are also changing where health services are needed and hospitals are located. The health system must adapt, or it will falter.

## We're building better services, not servicing more buildings

The number of hospitals is not the measure of a successful health system. Thanks to new technologies and practices and more out-patient treatments, thousands fewer hospital beds are needed. Funds spent maintaining underused buildings can be better used to provide direct health care. Changes must be made.

## Enhancing local health services

The Commission is recommending a comprehensive health system with a strong hospital as well as enhanced community services. Details include:

- A comprehensive hospital system consisting of one hospital, with most services consolidated on the General site by December 2002. The F Wing of the Plummer Memorial site will also remain open for ambulatory care including dialysis and women's health.
- Recommended reinvestment of $45.6 million for renovation, expansion and equipment projects in hospitals and $17.2 million in annual spending for enhanced services such as long-term care, acute home care, mental health and rehabilitation.
- The total capacity of the health system will be 289 beds, including acute care, sub-acute care, mental health, rehabilitation and complex continuing care to meet the needs of an aging population.
- Approval is given to begin planning for a one-unit radiation therapy satellite cancer centre in Sault Ste. Marie.
- Recommended annual funding of $1 million to operate MRI equipment to support convenient diagnostic work for the community.

## Planning change carefully, one step at a time

On January 20, 1999, the Commission announced preliminary recommendations to preserve and enhance the quality of the health system in Sault Ste. Marie. Since then, comments have been received from local hospitals, other health care providers, community organizations and individuals. The distinct needs of the community have been carefully addressed.

## More coordination for better services

- The Commission is directing the Sault Area Hospitals to create a Joint Executive Committee with the Group Health Centre to establish shared strategic planning and decision-making for the services they offer. The Commission also believes that closer working relationships will reduce duplication, enhance physician recruitment/retention and increase the services available to patients.

## More services for the elderly

- Sault Ste. Marie will be able to meet the growing need to provide services to the elderly, with $10.1 million to be invested annually in long-term care and $1.8 million in home care.

## French language services will be strengthened

- The HSRC plan calls for the strengthening of French Language Services by directing the Sault Area Hospitals to seek designation to provide services in French according to the French Language Services Act. The hospitals will develop and implement a plan to provide these services with the assistance of the Ministry of Health.

## Building a better health system for Ontario

During the past three years, the Commission has recommended across Ontario:

- Over $2 billion in hospital building and equipment improvements.
- Over $1 billion to be spent annually in new services in areas such as rehabilitation, mental health and home care.
- The addition of almost 17,000 long-term care beds to the health system.

## We have more information available

This advertisement was placed so that people can know more about these important changes. If you would like additional information about health services renewal, you can call 1-800-565-4453 during business hours or write to 56 Wellesley Street West, 12th Floor, Toronto, Ontario, M5S 2S3, or visit the Web site at www.hsrc-crss.org.

BUILDING A BETTER HEALTH SYSTEM

**HEALTH SERVICES RESTRUCTURING COMMISSION**

# Section II:
# Creating a Vision of the Future Health System

## Developing the Vision: Key Challenges

## HSRC's Vision of the Future Health System

## Response to the HSRC's Vision

HSRC

# SECTION II: CREATING A VISION OF THE FUTURE HEALTH SYSTEM

The need to develop a vision of what Ontario's future health services system might look like was identified at the HSRC's inaugural meeting (April 1996). The vision was considered important for a number of reasons:

- To explain the context of the HSRC's work and to ensure hospital restructuring decisions made sense in relation to an overall plan (i.e., articulate a working hypothesis for the work of the Commission).

- To clarify the reasons for change and the expected outcome of reforms.

- To provide a focus for generating public and provider feedback on the vision itself.

## Developing the Vision: Key Challenges

Across the country, a series of reports released on health reform have consistently identified three objectives for reforming provincial health systems:

i. Rebalance the system between institutional and non-institutional services and put more emphasis on appropriate care (and resource requirements) along the entire continuum of care;

ii. Better integrate and co-ordinate care so that it appears "seamless" to patients and their families; and

iii. Create a patient-centred, as opposed to hospital-centred, system.

Each province has struggled with how best to meet these objectives and in so doing overcome a number of challenges, including the following:

**Lack of a shared vision of the future health system:** What it is and how will the quality of care and life for consumers be different when the vision is achieved?

**Provider and consumer resistance to implementing change:** Resistance to reform from both providers and the public is a major constraint in securing support for health care reform. Recommendations to shift the emphasis and funding of any organization or system leads understandably to resistance from those organizations and individuals from which resources are to be taken away.

**Physician reimbursement system (fee-for-service) and organization:** In Ontario, the 1995 MOHLTC/OMA agreement required resources for alternative funding plans to come out of new money rather than the current OHIP budget. This was perceived by some to be a roadblock to initiating alternative payment plans that have greater potential than fee-for-service as incentives for leading to greater integration of the many individuals, institutions and organizations necessary in the health system.

**Competing policy and priority agendas:** There are an array of competing and conflicting policy initiatives at the provincial level.[9] Each of these has its own distinct set of stakeholders both within government and across the province. The challenge is to get all of the constituencies to set aside their sectoral prerogatives and priorities in the interest of a shared vision of an integrated system.

[9] In Ontario, these have included, for example, the creation of CCACs, physician fee negotiations with the OMA and the downloading of community health services to municipalities.

**Entrenched tradition of "silo" funding to health care sectors:** The incentives in the current health system(s) have resulted in organizational structures in which each provider works within its own budget, and does not even communicate easily with other providers. In consequence, too many people fall between the cracks and do not receive the optimum continuity of care. In addition, there is a lack of trust among the different silos (i.e., organizational structures, be they hospitals, long-term care facilities, Community Care Access Centres (CCACs), community mental health agencies, etc.).

**New medical technologies and the changing role of hospitals:** Hospitals are no longer defined purely in terms of in-patient beds. At the time of the establishment of the HSRC, thousands of hospital beds had been closed across Canada (about 9,000 in Ontario) but, with few exceptions, no hospital buildings. Some of the money that should have been spent on front-line care was being used for infrastructure such as unused buildings or portions of buildings. Things were likely to get far worse: a staggering proportion of Ontario's hospitals had been built in the post-World War II period, and were reaching the end of their useful life. Billions of dollars in renovation costs would be needed.

It was essential to ensure these capital dollars would be used wisely. At the same time, however, the general public continued to have strong attachments and loyalty to their local hospitals. There was a tendency amongst the general public and elements of the health care community to concentrate on physical structures rather than *services*.

**Focus on cost containment/redistribution of costs:** Every province has struggled to determine the opportunity costs associated with trying to ensure that the total amount of money devoted to any activity — including health care — does not detract from or preclude investment in other equally worthy endeavours. Thus, the total costs of health care must be maintained within an acceptable and affordable level. People must be assured that their money is spent wisely; there is, a need for good management.

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## HSRC's Vision of the Future Health System

In January 1997, the HSRC released a draft vision statement outlining the desirable characteristics and structure of Ontario's health services system (see Figure II-1). The vision document described the future health system as a "series of inter-connected, integrated health systems and integrated academic health systems." These 'systems', comprised of groups of hospital and community health organizations, would be responsible for the health care of a defined population.

The vision document was a working hypothesis used as the basis for further development of a policy framework and recommendations on specific steps and strategies required to move from the vision to actual system-building.

The vision document also described some essential building blocks of the future health system (see Figure II-2 ).

**Figure II-1: HSRC's initial vision of the future health system (January 1997)**

*Our vision is of a publicly administered health services system that provides [illegible] comprehensive, accessible and portable services that meet or exceed [illegible] benchmarks. A provincial system organized to provide the [illegible] with [illegible] diversity among its elements and decision-making by the people affected. It is [illegible] together provide the full spectrum of health services needed to promote health and [illegible] Ontario's population.*

*We see a health services system in which regions, the sectors and their [illegible] organizations are distinctive, but committed to purposes in common. The [illegible] sector, institution, and organization are integrated, and complement [illegible] of [illegible] provincially set policies, goals, objectives, and priorities necessary to achieve [illegible]*

[10] Primary care, home care, long-term care, hospital sector, etc.

[11] The following Vision of Health was developed by the Ontario Premier's Council on Health Strategy and endorsed by all parties of the Provincial Legislature in the Spring of 1989: *We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work, and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender, or cultural background. Finally, we see everyone working together to achieve better health for all.*

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**Figure II-1: HSRC's initial vision of the future health system (January 1997)**

> *Our vision is of a publicly administered health services system that provides universally available, comprehensive, accessible and portable services that meet or exceed internationally-derived performance benchmarks. A provincial system organized to provide the patient with better continuity of care and foster diversity among its elements and decision-making by the people affected, it is constituted of sectors[10] that together provide the full spectrum of health services needed to promote health and provide health care for Ontario's population.*
>
> *We see a health services system in which regions, the sectors and their component institutions and organizations are distinctive, but committed to purposes in common. The contributions of each region, sector, institution, and organization are integrated, and complement those of all others to meet the provincially set policies, goals, objectives, and priorities necessary to achieve Ontario's vision of health.*[11]

[10] Primary care, home care, long-term care, hospital sector, etc.

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**Figure II-2: Essential building blocks for achieving the vision**

| CLUSTER 1: CORE REQUIREMENTS OF ALL SYSTEMS | |
|---|---|
| **Common vision** | All sectors and constituent institutions and organizations share a common vision. |
| **Shared goals, priorities and performance standards** | Sectors have shared goals, priorities and performance standards to optimize accessibility and quality of service. |
| **Values and outcomes** | Sectors have shared values to achieve shared outcomes. |
| **Backdrop of provincial legislation, policy and standards** | Policies and plans are set by the MOHLTC and adjusted periodically in response to ongoing evaluation of how well the system is achieving the government's goals and objectives. |
| **CLUSTER 2: SYSTEM FOCUS** | |
| **Research and development** | Improving the knowledge upon which administrative and clinical decisions are made with outcome-based decision-making focused on quality of care, quality of outcomes, and performance measurement. |
| **Population health**[12] **and balance between health care and health** | System's focus includes population health as well as individual health, balancing the allocation of resources to achieve the long-term goal of enhancing the population's health, and the immediate imperatives of diagnosing and treating illness. |

[12] Since the late 1980s, the term "population health" has been used to describe the multiplicity and range of elements which collectively contribute to health.

| CLUSTER 3: NEW SYSTEM STRUCTURE | |
|---|---|
| **Common information system** | Shared information system capable of providing comprehensive, up-to-date and accurate data and information to plan, co-ordinate and operate the integrated health service system. |
| **Vertical and horizontal integration** | The diverse institutions and organizations that offer the same type of services are organized horizontally into sectors. These sectors are vertically integrated so they operate together within each geographic region. |
| **Primary care** | Reformed primary care system that serves as the first point of contact people have with health services and as the connector to the rest of the system. |
| **Incentives and diversity in encouraging strategic alliances that support greater integration and efficiencies** | The system fosters local, district and regional initiatives and diversity and achieves horizontal and vertical co-ordination among institutions, organizations and sectors. |
| **CLUSTER 4: OPERATIONAL CHARACTERISTICS OF THE NEW SYSTEM** | |
| **Shared accountability** | Fiscal envelopes and purchaser-provider concepts (among others) are used to achieve specific objectives and safeguard particular services such as mental health and children's services. |
| **Incentives** | Incentives are created and disincentives removed to encourage providers and consumers to make and keep people well. |
| **Leadership** | Professionals and others provide strong leadership and commitment to meet current and evolving health care needs. |
| **Capitation funding** | Envelope funding to allow organizations to meet the total health needs of a defined, registered (rostered) population, and operate within the financial limits of individuals, the public purse and the provincial economy. |

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## Response to the HSRC's Vision

Over 140 submissions were received in response to a formal request from the Commission for written feedback on the January 1997 vision document. The majority of the feedback was from key provider groups and provincial health care organizations. Support was expressed for the following core ideas in the document:

- general thrust and message of the vision statement
- characteristics/building blocks of the future health system
- the concept of "integrated systems"
- reaffirmation of the principles of the Canada Health Act and the need to meet performance benchmarks
- the idea of promoting a "flexible" approach for developing different models of governance and ownership in a reconfigured health system
- a strong central policy role led by the MOHLTC
- development of a strong provincial health information management system

Concerns were expressed about the following:

- lack of consumer focus
- the conceptual/theoretical tone of the vision statement
- the magnitude of the change required to develop a more integrated health system in Ontario
- lack of emphasis on the need to ensure, preserve and strengthen teaching and research activities in the health system
- too much emphasis on structural issues (i.e., IHS development) and not enough emphasis on the determinants of health and population health
- the impact on human resources/labour that would result from further changes to the health system
- willingness and ability of the MOHLTC to support and expedite required reforms (e.g., changes in physician remuneration, rostering, primary care reform).

Throughout the next year, the HSRC worked on revising the vision statement. The Commission Chair spoke frequently at conferences and other events about the importance of having a vision and the HSRC's attempts to develop one.

In early 1999 the HSRC approached a number of individuals/organizations and invited them to convene a round table of stakeholders in their field to solicit feedback on what they believed to be important issues for moving health system reform forward. The need to state and communicate a vision of health reform was identified most frequently as a key priority for planning future health system reforms. A number of round table respondents suggested that the vision be developed in the form of a "provincial blueprint" setting out specific goals and objectives of reform and describing the future design of the health system. The system design should address the needs, desires and concerns of consumers.

There was, however, no consensus on *what* to include as part of the vision. Rather, there was a wide range of opinions expressed related to positioning and content. It was suggested, for example, that the vision should –

- Be driven by and focus on consumers with input from clients/users and primary care providers;
- Help educate the public about the necessary changes in health care delivery to enhance confidence, achieve buy in, and develop realistic expectations of the health system;
- Incorporate and consider the relevance of the health system to changing environmental and population trends;
- Form the basis for future discussions regarding the form, structure and organizational 'models' to be considered as part of the health reform agenda;
- Establish the basis for developing a strategic plan with clear goals, objectives, and strategies for shaping and building a co-ordinated health system;

- Place strong emphasis on health promotion, disease prevention and the importance of the broader/social determinants of health;[13]
- Reference the need for standards/benchmarks to ensure "a meaningful integrated accountability framework" related directly to expectations (i.e., improvements in health status outcomes).

The majority of feedback received on the HSRC's vision statement was from provider groups. In an attempt to respond to concerns that the statement was not consumer friendly/focused, the HSRC sponsored a series of consumer focus groups in November 1999. The purpose was to determine the public's reaction to the statement and to try to convert the *conceptual framework* of the vision into mental images and language the public would understand and accept.

The following four themes emerged in feedback received from the consumer focus groups:

i. People are aware the health care system has problems;
ii. There are concerns about system abuse;
iii. There are concerns that there is too much political involvement; and
iv. People believe cuts and changes are being made too quickly, without enough long-term thought, and may be going too far.

Reactions to these issues/concerns varied notably by the consumer's age. Older consumers who for the most part had more direct experience with the health care system, and were there during the early "glory days" when the system represented huge progress over what existed "pre-Medicare," described the current system as "good", "adequate", "coping". They are thankful for it and optimistic about its future. They see it as close to ideal.

Younger consumers, however, have been exposed to negative information from the media about the current health care system and have less direct experience with it. They tend to see it as remote/distant and describe it as "declining", "broken", "tired". They are resentful at the prospect of having a "lesser" system and are pessimistic about its future. They see it as the opposite of ideal.

The features or attributes of the ideal health care system, from the consumer perspective, included the following:

- stability/lifelong/feeling of confidence in it
- accessible/available
- compassionate
- efficient (as well as integrated, organized, and co-operative between its elements)
- no abuse, sensible use/administration of funds
- available for everyone
- quality services (good health, superior care)
- comprehensive
- straightforward, comprehensible

Key concerns expressed about the HSRC's vision statement were that it "lacks the patient perspective" (e.g., caring, compassion), was "dry" and "corporate" in tone, was unclear, and that it sounded competitive (among the elements making-up the system) when co-operation is the intent, and the desire. The vision statement was also seen to be too long ("one paragraph please"), wordy ("too much in it"), and some words used were considered inappropriate for a public audience.

[13] Several suggested that the vision should build on the advice and recommendations contained in the many previously released reports and plans for implementing health promotion into the health system that have been published by the Centre for Health Promotion (University of Toronto), the Canadian Institute for Advanced Research (CIAR) and the former Ontario Premier's Councils.

Consumers agreed with the first and last lines and the ideas covered in them. They disliked the jargon (e.g., benchmarks, diversity, internationally derived, sectors) and found many of the terms difficult to understand, politically charged and lacking the human element that is crucial to the health system. The two main points that were thought to be missing related to timelines and the financial element (i.e., how will the new system be paid for). The former is important for obvious reasons; the latter is important because consumers recognize money is behind the changes being considered.

With this information in mind, the HSRC concluded its mandate by proposing the following as a revised vision statement:

**Figure II-3: HSRC's 'final' vision of the future health system (January 2000)**

*Our vision is of a sustainable health system that provides compassionate, comprehensive, high quality care to everyone who needs help to regain and maintain good health.*

*While reflecting community and regional differences, the system's health care providers work together toward the common purpose of meeting the publicly set goals, objectives, policies and priorities necessary to achieve Ontario's vision of health.* [14]

The vision statement is not, nor should it be, static. The content of the vision should be shaped by the views of the many players who have a stake in the health system, including government decision-makers, public and private health care organizations, providers, and health consumers.

One of the principal reasons why the health services 'system' is as fragmented as it is in Ontario is that, as a system, it has no overarching governance/leadership. The many elements that make up the 'system' — hospitals, physicians, long term care facilities, etc. — are closely regulated but in almost every case by different statutes that were not themselves created from a systemic perspective. Although the MOHLTC is the primary locus of this regulation or management, the Ministry itself is fragmented. That fragmentation is, understandably, then reflected "downward" throughout the system that has, in effect, no *real* leadership.

The first requirement of any 'system' (a co-ordinated enterprise) is that the several parts of which it is made have to march to the beat of a single drum. In ordinary parlance, that drumbeat is the vision of the organization. In the absence of a common vision and subsequently the corresponding statements of mission, goals, objectives and so on, a true health services system cannot exist.

Therefore, the Commission recommends that the government (acting through the MOHLTC) take the first and most significant step toward the establishment of a governance for the health services system and articulate the vision of what this system is to be and do for the people it serves. As a starting point, the government should use the HSRC's vision to engage the public in a discussion of the future health system.

[14] The following Vision of Health was developed by the Ontario Premier's Council on Health Strategy and endorsed by all parties of the Provincial Legislature in the Spring of 1989: *We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work, and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender, or cultural background. Finally, we see everyone working together to achieve better health for all.*

# Section III:
# Analysis and Evaluation of Restructuring Options

## Configuration of Hospital Services: Capacity Requirements and Siting Options

## Cost Methodology

HSRC

# SECTION III: ANALYSIS AND EVALUATION OF RESTRUCTURING OPTIONS

The HSRC operated at arm's length from the government and acted independently in its decision-making related to hospital restructuring. While the Commission was delegated the power of the Minister of Health under the Public Hospitals Act to close and merge hospitals and to move clinical activity between hospitals, authority over the funding of hospitals remained with the Minister of Health.

The HSRC's reports, *Notices of Intention to Issue Directions*, *Directions*, and advice to the Minister were developed based on a framework of analysis that included the following:

- Establishment of performance benchmarks for acute in-patient care
- Application of mental health in-patient benchmarks
- Application of benchmarks for sub-acute care[15], complex continuing care (chronic care) and rehabilitation
- Application of projections for growth and aging of the population
- Decisions about facilities to be closed or amalgamated
- Governance
- Need for reinvestment in other sectors of the health care system
- Investment in infrastructure and other one-time costs associated with restructuring

The principal points of deliberation rested on four key areas:

- *Configuration of hospital services* based on determining capacity requirements for acute in-patient, sub-acute, rehabilitation, mental health and complex continuing care beds and a review of potential siting options.
- Development of *costing methodologies*.
- Review of *governance models* to support the 'restructured' system.
- *Reinvestments* required to support the 'restructured' system.

The first three of these are reviewed briefly below. The issue of reinvestments is discussed in Section V of this report.

[15] The HSRC defined sub-acute care as follows: *Hospital-based in-patient care provided on a supervised in-patient unit of a hospital for individuals in need of slower paced recovery following surgery or short-term medical treatment and convalescence following an acute medical episode. The distinction between sub-acute and other types of care relates to the nature of the medical supervision, the degree of invasive diagnostics and procedures, the stability of the illness or disability and the service requirements of the patient. Sub-acute care is aimed at patients who need to regain function and restore their independence prior to re-integration into the community and discharge to their home setting. Patients receiving sub-acute care suffer from a loss of function as a result of an acute episode or extended stay in hospital, are deemed likely to regain function following a course of treatment and care focused on reactivation and restoration and, cannot receive conventional home-based services to manage their care requirements.* It should be noted that the MOHLTC did not endorse the concept that sub-acute care should be established as a separate category of funding. Rather, in January 1999, the MOHLTC advised hospitals that they would be treating the HSRC's sizing of sub-acute care as part of their acute care complement. Section V (reinvestments) includes a further discussion of the MOHLTC's sub-acute care policy.

## Configuration of Hospital Services: Capacity Requirements and Siting Options

The following general process was used to develop an appropriate configuration of hospital services:

1. Estimate total bed requirements by assessing utilization indicators, benchmarks and referral patterns for acute care, complex continuing care (formerly chronic care), rehabilitation, mental health and sub-acute care.

2. Develop options for the configuration of hospital services taking into account facility capacity, quality indicators (including optimal critical mass and clinical coherence for service delivery) and access indicators.

3. Assess the configuration options against the criteria of quality, accessibility and affordability.

4. Determine the "sensibility" of the overall decision.[16]

*Acute Care Bed Requirements:* Estimating acute care bed requirements began with a review of 1995-96 utilization data for acute in-patient services to identify ways to improve efficiencies in in-patient acute care services, thereby reducing bed capacity.

The benchmarking used to assess clinical efficiency of acute care services was based on best practices in many instances and existing provincial policy in others. In some instances, best practices related to average performance within the hospital sector in Ontario, while in others, the best 25 per cent performance levels were used (i.e., 75th percentile).

The HSRC also adopted the MOHLTC's Planning Decision and Support Tool (PDST) methodology.[17] Utilization improvements were benchmarked as follows:

- 100 per cent of alternate level of care (ALC)[18] days were removed
- 100 per cent of avoidable admissions[19] were removed
- In-patient surgery was converted to day surgery, where appropriate (75th percentile)
- Average length of stay (ALOS) was reduced (75th percentile for 1995-96 cases)

The major criticisms received regarding the HSRC's acute in-patient benchmarks were:

- No one hospital achieves benchmark performance in all case mix groups

[16] This last step was referred to by the Commission's Chair as the "man on the moon test" (after D.L.Wilson, Dean, Faculty of Medicine, Queen's University, 1982-88).

[17] The PDST is a LOTUS 123-based software application containing data and statistics relevant for planning in health care. The PDST includes data and related statistics for most health care institutions in Ontario. The program promotes the review of any institution's operations including clinical efficiency relative to any other institution in the local community and Province; assessment of the current utilization patterns and trends; and, assessment of current activity in each institution in relation to both county and provincial levels.

[18] ALC cases are those where the patient is ready for discharge from an acute care bed, but the required alternative level of service is not immediately available. The patient must then occupy an acute bed when his/her needs could be better met in another type of setting, such as a long-term care facility. The reporting of ALC cases is a clinical decision and must be indicated on the patient's chart by the attending physician.

[19] Avoidable admissions were measured by the number of distinct case types that could be provided on an ambulatory basis or diverted to other service providers in both the health and social services system. Admissions categorized as avoidable included: case mix group CMG 851 – "Other factors causing hospitalization" and CMG 910 – "Diagnoses not generally hospitalized".

- The occupancy levels that for the most part determine the size of buildings are too aggressive
- HSRC reports exhibit a degree of "precision" and "forced compliance" with benchmarks that are not sensitive to local considerations
- The HSRC does not adjust for variation in admission rates or historical inequities in funding patterns
- The HSRC conclusions are perceived to be "driven only by numbers"
- The HSRC failed to consider adequately established referral patterns especially to AHSCs

The HSRC's response to these criticisms was to explain that actual admission (separation) rates to hospitals were not adjusted (i.e., lowered); they were accepted as characteristic of the community concerned. Rather, utilization rates were determined based on 1994-95 *actual performance* benchmark utilization in terms of length of stay. The acknowledged difficulty with this approach is that communities with high in-patient admission rates could achieve performance improvement through a combination of reductions in admissions by service substitution to ambulatory and community services and by reductions in length of stay. On the other hand, communities with low admission rates had to rely primarily on reductions to length of stay to achieve benchmark performance.

Most hospitals considered the 75th percentile for length of stay to be achievable. However, it was recognized that some monitoring and adjustment might be required depending on local circumstances and conditions. In addition, however, the HSRC believed it was important to recognize two factors:

- Many hospitals within Ontario will (and do) exceed the targeted benchmarks, and
- Other jurisdictions have achieved much more aggressive utilization targets.

The question of how flexible the HSRC should be in terms of capacity arose frequently. In the end, the HSRC was convinced that it should hold firm on length of stay benchmarks. It believed it important to consider historical referral patterns, but develop an approach to begin to address increasing volume in particular areas where this may be warranted (i.e., joint surgery, cardiac surgery, and cancer-related services).

*Estimating Growth in Clinical Activity to the Year 2003*[20] *(Growth Methodology)*: The HSRC reports outlined population projections to 2003 and determined capacity projections based on existing practice.[21] The HSRC developed a growth methodology for determining appropriate service utilisation in the future. The methodology was adapted from that developed for the *Growth Funding Working Group* of the Ontario Joint Policy and Planning Committee (JPPC) in May 1996.

Growth was projected to the year 2003 and calculated on a program-by-program basis so that when programs were transferred between facilities, the associated growth reflected in those programs was also moved.

[20] The HSRC was advised by the MOHLTC to size services and determine required reinvestments based on a 2003 planning horizon (i.e., population growth projections). This target date was sufficiently distant to allow for implementation of most, if not all, HSRC restructuring *Directions* and fit well with the existing reform policies of the MOHLTC. Any later date would have resulted in imprecise census projections and could have led to significant errors in the sizing of hospital based services as well as the complementary services in home care and long-term care facilities. Additional information on the HSRC's growth methodology(ies) is found in Appendix C.

[21] The difficulty with this approach is that the HSRC did not make reinvestment decisions for increases in volume as the population ages and expands.

The four steps required to calculate growth were:

1. Determine the population change from 1995 to 2003 using projected populations which, province-wide, average at about a 2.3% increase annually.

2. Calculate the impact of population change on the utilisation of hospital services using case type and age-specific and gender-specific use rates projected against population growth. Calculations were done for each County population in Ontario.

3. Allocate the impact of population change to the post-utilisation volumes on a program-specific basis to each facility. Estimate the impact of growth on the change in the demand for hospital services by using a blend of two factors:
   - the historical referral patterns based on the proportion of cases by age, gender and major clinical category (MCC)
   - a 'proximity' factor based on the assumption that an individual will receive services from the eligible hospital closest to his or her home.

4. Total the projected post-utilization days for each facility (projected for growth) and estimate the number of equivalent beds required in 2003.

The key limitations associated with the HSRC's method for estimating the growth in clinical activity associated with population growth were related to two key factors:

1. Current levels of services may not be a good proxy for levels of activity when utilization improvements are taken into account, and
2. Impossibility in predicting changes in disease or illness patterns.

## Cost Methodology

While the cost savings estimates developed by the HSRC were not part of the *Directions*, they were included as *advice to the Minister*. In assessing costs and savings, the HSRC built upon the Ontario Cost Distribution Method (OCDM), which augments the Canadian Hospital Association Management Information System requirements.

The purpose of developing a costing methodology was to estimate the affordability (i.e., potential costs and savings) associated with various restructuring options. The methodology itself involved the development of savings estimates related to four areas:

i. Clinical efficiencies
ii. Consolidation of support services
iii. Program transfer/restructuring savings
iv. Administrative efficiencies

The sequence of determining the estimates was important to avoid "double counting" and improve the accuracy in estimating costs and potential savings. The general sequence of steps respecting costs and savings estimates inherent in the *acute care costing methodology* was as follows:

Step 1: Determine net expenses
Step 2: Calculate program (and related) transfers
Step 3: Calculate clinical efficiency savings
Step 4: Calculate savings associated with the consolidation of support services
Step 5: Reallocate other expenses[22]
Step 6: Calculate site closure savings
Step 7: Calculate administrative efficiencies

[22] Other savings may be identified through site closures and program reductions. These savings are community-specific and were based on net expenses as reported in the OCDM.

Costing hospital activity such as complex continuing care, long-term and acute in-patient mental health, rehabilitation services and sub-acute care also required development of specific 'costing' methodologies. Some of these methodologies were already available, while others required further development (see Appendix C for further details). Savings were not estimated for out-patient or ambulatory care services given that the data are not complete (or sufficiently accurate) to permit "reliable" benchmarking. Instead, the actual costs for these services were maintained in the methodology.

The results of application related to the various costing methodologies were summarized in each of the HSRC's key restructuring reports as part of its advice to the Minister, and the hospitals affected by the *Directions*. All estimates were qualified with a notation indicating that the actual expenses and savings predictions would require further development during implementation of the *Directions*.

# Section IV: Governance

## Analysis of HSRC Governance Decisions
## Governance Facilitation — Lessons Learned

# SECTION IV: GOVERNANCE

> *"Governance, as a structure, as a process, and as a symbol, is not a problem unless the imperatives of separate governance, the imperatives of so-called autonomy, stand in the way of system-building and coming quickly to rational, amicable solutions to the puzzle of how to best organize the institutional and organizational resources of the elements of the so-called 'system' into a real system."*
>
> (Duncan Sinclair, Chair, HSRC — Speech to the Annual Convention, Catholic Health Association, September 26, 1996)

In the 1992 report, *Into the 21st Century*,[23] governance responsibilities were defined as variable in scope among institutions and organizations providing an array of hospital based services; however, they were said to include common responsibilities:

- outlining purposes of the hospital, its goals, objectives, the hospital's mission, quality of patient treatment and care, relations with professionals, staff, the community and province, reporting relationships, public access and accountability
- defining and maintaining the principles, value, culture and ethical environment of the hospital, its relationships to its patients, the communities it serves and to other providers and stakeholders in the health system
- ensuring the long-term fiscal and physical viability and integrity of the hospital
- overseeing the effective management and financial health of the hospital
- ensuring and monitoring the quality of services in all aspects of hospital operations.

In retrospect, the task of making decisions on the configuration of hospital services was seen to be relatively straightforward compared to the decisions the HSRC was required to make on the governance structure(s) that would lead the restructured system.

Generally speaking, the DHC reports on restructuring did not provide comprehensive strategies (or in many cases even options) for redesigning governance to support a restructured health system. Many DHC reports, however, conveyed a common message: they pointed to the difficulties communities had in embracing the need to change traditional governance structures, especially if system improvement required a choice between two or more existing structures.

In fact, the HSRC discovered that where there was bitter rivalry between organizations or denominational governance was a component of restructuring, communities were often paralyzed. In most cases, the perceived 'costs' of making a choice between one organization and another, for example, were judged to be too great. As a consequence, the difficulties in developing appropriate governance options to support required restructuring was a major constraint in the efforts of some communities to restructure the local hospital system on their own. There were, however, some examples of where these difficulties were

[23] *Into the 21st Century - Ontario Public Hospitals Report of the Steering Committee*, Public Hospitals Act Review, February 1992.

overcome (e.g., Sault Ste. Marie, Chatham, Sarnia) to the great credit of those involved.

Early in the HSRC's mandate, the following principles were agreed upon to guide the development and evaluation of governance options for a restructured hospital system:

- The tradition of *voluntary governance* has served Ontario communities well over the past century and should be maintained and enhanced in a restructured health services system.

- There are significant benefits to be derived from the *diversity of traditions and cultures* that exists among hospitals and health care organizations in Ontario. Tradition and cultural differences must not, however, stand in the way of the necessary shift from autonomy to interdependence as the way to deliver more effective and efficient patient services.

- The priority of governance structures and functions must be to *promote interdependencies* on which a smoothly co-ordinated, strategically planned, functional system can be built and maintained.

- There is not one 'best' system/model of governance, but there is a *need to find better ways to promote greater integration, efficiencies and effectiveness* across the various components of the health system.

- New governance models should emerge that will allow *individual organizations to use their strengths and talents* to discharge their collective responsibilities and also to preserve and enhance the distinctiveness of each individual organization and institution.

- Testing better ways of governing will require the *development of a variety of models* — involving institutions and organizations with distinct backgrounds, attitudes and approaches. Specifics regarding the shape and design of the most appropriate structures and ways to implement them can best be developed locally.

In addition, there was agreement that all *Notices* and/or *Directions* issued by the Commission to hospitals should include a statement highlighting the importance of and need to ensure that the composition of [all] Boards is representative of the community they serve:

> *The governance structure [of the Board] must be representative of the communities served and have regard to the demographic, linguistic, cultural, economic, geographic, ethnic, religious, and social characteristics of the [community] region.*

There was further agreement that in cases where *new* boards were being created (i.e. through amalgamation of facilities), a further *direction* should be given concerning the composition of the board, namely:

> *[That governance] plans ensure that members of the new Board have relevant experience and expertise.*

The HSRC established various approaches to governance based, in large part, upon assessments of local circumstances. The HSRC was, however, primarily guided in its decision-making by its general principles set out above.

There are various methods to enhance connectivity and close relationships among hospitals. The choice of an appropriate governance structure to promote greater integration and connectivity must, for example, take into consideration the attributes of different governance models, as well as local preferences and the objectives and needs of the proposed entity.

Figure IV-1 summarizes the terms and language used by the HSRC to describe the various governance options considered in its work.

**Figure IV-1: Governance options and definitions of terms**

| [illegible] | Definition | Essential Elements |
|---|---|---|
| [illegible]mation [24] | Two or more separate hospital corporations joining together and continuing as one corporation in accordance with the provisions of the Corporations Act and the Public Hospitals Act.<br>[Note: this means that hospitals not separately incorporated or those incorporated under a Special Act or any Act other than the Corporations Act would have to be continued/incorporated under the Corporations Act before amalgamation could take place under that legislation.] | Results in a new corporate entity, *i.e.* a permanent structure with legal existence separate from that of its founders and limited liability of founders, as opposed to a contractual arrangement.<br><br>In order to amalgamate, there must be full compliance with provisions of the Corporations Act.<br><br>Approval is necessary from the Minister of Health, the Public Guardian and Trustee and the Ministry of Consumer and Commercial Relations.<br><br>The result can be one corporation absorbing the other or in the emergence of a merged corporation with new objects, arising out of the amalgamating corporations, *i.e.* amalgamation need not be a take-over and may be politically more palatable than closure and asset transfer. |
| [illegible] Agreement | When two or more hospitals agree by contract to combine funding and management, clinical and/or support resources in order to enhance quality and improve the delivery of hospital services through consolidation, without creating a corporation. | Created by way of a contract that might include the following: the purpose and scope of the alliance; the location of its principal office; the term, *i.e.* duration of the agreement; the amount of any capital contributions to the alliance by each participant; procedures for accounting, financial and other records; dissolution and liquidation agreements; dispute resolution mechanisms; management of the alliance, including the assigning of decision-making authority and the duties of each participant. |

[24] The amalgamations discussed here are those made pursuant to the Corporations Act, Ontario's legislation governing not-for-profit corporations. These may be referred to as "statutory amalgamations". Under this statute, corporations follow the prescribed statutory procedure to become amalgamated [section 113 of the Corporations Act].

| [illegible] | Definition | Essential Elements |
|---|---|---|
| [illegible] Executive Committee (JEC) [25] | A body comprising representatives of the governing boards of two or more participating hospitals that has authority to make operational decisions for the participating hospitals to facilitate integration and linkages among the hospitals, the services they provide, the programs they operate and their clinical, professional and administrative personnel. Requires the majority of directors from each organisation to agree to action. | Participating hospitals continue to exist as separate entities, subject to delegation of certain authority to the JEC.<br><br>Decision-making authority related to specific issues is explicitly delegated by the governing boards to the JEC.<br><br>The relationship should be created by way of written agreement/contract that ideally sets out by-laws or protocols on the conduct of affairs and operations of the JEC, including accountability and reporting requirements with respect to governing boards. |
| [illegible] / Agreement | A written, legally enforceable document setting out the nature of the [integrated] relationship between two or more hospitals, including the contractual rights and duties of each party and any remedies and penalties for breach of such duties. | Meets the legal tests for a valid contract, e.g. offer, acceptance, consideration, consensus, etc.<br><br>Sets out the exact nature of the contractual rights and duties of each party as well as the remedies and penalties for breach thereof. |
| [illegible] Management/ Administration Contract | A contract between two or more hospitals, setting out the contractual rights and duties of each party relating to shared, integrated or consolidated administrative and/or management personnel and/or services, including, without limitation, the chief executive officer, the management team, administrative staff, information systems and technology and professional personnel and/or services. | |
| [illegible] Support Services Contract | A contract between two or more hospitals, setting out the contractual rights and duties of each party relating to shared, integrated or consolidated support personnel and/or services, including, without limitation, security, purchasing, housekeeping, food services and laundry personnel and/or services, but excluding laboratory services. | |

[25] JECs may focus simply on strategic planning and decision-making relating to programming, clinical linkages and consolidation of administrative, support and clinical services. They may, additionally, be granted decision-making authority on resource management and operations and, further, over implementation of shared management, administration and clinical leadership and integrated operating plans, information system and human resources adjustment plans.

| | Definition | Essential Elements |
|---|---|---|
| [illegible] Services [illegible] | A contract between two or more hospitals, setting out the contractual rights and duties of each party relating to shared, integrated or consolidated clinical personnel and/or services, including, without limitation, medical, dental, nursing, psychology, social work, pharmacy, occupational therapy and physiotherapy personnel and/or services. | |
| [illegible] Operation and [illegible] | A *Direction* that the board of a hospital corporation relinquish operation, management and control (and in some instances ownership) of the hospital to another hospital corporation means that the "relinquishing" hospital corporation ceases any involvement in the operation of the hospital. The board of the hospital corporation to which operation, management and control is transferred assumes (subject to any *Direction* to the contrary) sole responsibility for the provision of the programs and services of the hospital that is "relinquished" and for the management of its resources and assets. | *Relinquishing hospital* refers to a hospital directed by the HSRC to relinquish operation, management and control of some or all of its programs or services (and in some instances ownership) to another hospital.<br><br>*Receiving hospital* refers to a hospital which the HSRC has directed the operation, management and control of programs or services (and in some instances ownership) be transferred from a relinquishing hospital. |

## Analysis of HSRC Governance Decisions

The HSRC's reports on hospital restructuring were interpreted by some as a threat to the continuation of denominational hospital governance. They were not, nor were they intended to be. Subsequent to the HSRC's restructuring of Ontario hospitals, denominational hospitals remain vibrant contributors to the health care of many communities and to the province as a whole.

System building requires greater interdependence of hospitals with one another and with other institutions and organizations. Achieving interdependence while preserving the benefits of diversity, cultural differences and traditions represents a significant challenge to denominational and secular hospitals alike.

The HSRC was aware from the beginning that the diversity of the province would not allow "one model to fit all situations". Rather, several governance options were required, all within broad policy parameters. As such, the HSRC's discussions concerning governance were built on the following beliefs:

- There are benefits of diversity within integration.
- Restructuring provides a way to explore new roles within a redesigned structure that will promote and preserve the benefits of diversity.
- Flexibility in design can be maintained while ensuring a structure that will support restructuring.
- Discussions of governance should be separated from those concerning management.

- The HSRC should provide latitude to maintain denominational governance structures where appropriate, either as standalone corporations or as subsidiaries.
- The HSRC should refer to, and where possible build on, prior, established and successful precedents (e.g., the denominational/secular governance structure established in Sault Ste. Marie).

One of the immediate outcomes of urban hospital restructuring has been the achievement of significant consolidation, initially of governance and subsequently senior administration. This first step of achieving a restructured governance structure holds great potential for consolidating administrative and support services and clinical programs. In the long term, the HSRC expects that more resources will be reassigned to patient care as a consequence of hospitals achieving administrative and support services efficiencies.

### Appointment of Facilitators

In a number of communities, the HSRC recommended the appointment of a facilitator to assist the parties in to meet the HSRC *Directions*. In most cases, facilitators were called upon to help lay the groundwork for bringing governances together as a first step in implementing HSRC *Directions*. The role of the facilitator(s) appointed by the HSRC was:

- To create and maintain an environment that supports an effective working relationship between the parties so they can address issues constructively and resolve conflicts expeditiously.

- To consult (as required) with the legal advisor appointed by the HSRC with regard to legal interpretation of the HSRC's *Directions* and applicable legislation, and the appropriateness of governance options and organizational relationships being considered by the parties.

- To establish and build accountability with both the hospitals and the HSRC, defined by the HSRC as follows:

  - At the beginning of the process, it is expected that the facilitator will meet with hospitals separately to identify each hospital's issues, interests, expectations and options for mutual benefit.The facilitator will work with the hospitals to develop a work plan agreeable to all parties that includes a clear statement of ground rules, deliverables and timelines.

  - The facilitator is appointed by the HSRC and is accountable to the HSRC for assisting the parties in meeting the *Directions*.

  - The facilitator to notify the HSRC, with the knowledge of all parties, where progress is not as expected, proceedings break down or a party withdraws. The HSRC may request a final report and recommendation(s) from the facilitator.

  - In circumstances where the HSRC determines there is a continuing role for the facilitator in addressing unresolved issues and finalizing further *Directions*, the HSRC will inform the parties.

The facilitators were also responsible for providing reports at the request of the parties or, where considered appropriate, by the facilitator. In most cases, the hospitals involved in facilitation were responsible for covering the cost of the facilitator(s).

Figure IV-2 provides a summary of the key facilitators that were appointed by the HSRC in communities across the province to assist in the implementation of the HSRC's *Directions*.

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## Figure IV-2: HSRC appointed governance facilitators

| FACILITATOR | TASK/PROJECT |
|---|---|
| [illegible] Armstrong | Haliburton, Kawartha, and Pine Ridge (HKPR): Assist with Board structure changes for the *Northumberland Health Care Corporation* |
| [illegible] Connect/ Pauline Pillemer | Metro Toronto: Amalgamation of *Orthopedic and Arthritic Hospital, Sunnybrook Health Science Centre* and *Women's College Hospital* |
| [illegible] Decter | GTA/905: Amalgamation of *Peel Memorial, Georgetown and District Memorial,* and *Etobicoke General*<br>Kingston: Investigate potential of an interim agreement between *Hôtel Dieu Hospital, Kingston General and Providence Continuing Care Centre* (working with A. Hudson) |
| Michael Delaney | Metro Toronto: Transfer of operation and management of programs and services of *Doctors Hospital* to *The Toronto Hospital* |
| Claude Halpin | GTA/905: Amalgamation of *Oakville Trafalgar Memorial* and *Milton General and District* |
| Christine Hart | Metro Toronto: Transfer of the operation and management of *Wellesley-Central* to *St. Michael's* |
| Tom Heintzman | Metro Toronto: [resolution of outstanding issues] re: *Amalgamation of Orthopedic and Arthritic Hospital, Sunnybrook Health Science Centre, and Women's College Hospital* |
| Alan Hudson | Kingston: Investigate potential of an interim agreement between *Hôtel Dieu Hospital, Kingston General and Providence Continuing Care Centre* (working with M. Decter) |
| Hugh Kelly | Metro Toronto: Development of a plan to transfer responsibility for the operation and management of programs and services at *North York Branson* to *North York General*<br>Pembroke: Development of a governance plan for *Pembroke General* |
| Graham Scott/ Maureen Quigley | GTA/905: Amalgamation of *Whitby General Hospital, Oshawa General Hospital, North Durham Health Services, and Memorial Hospital* (Bowmanville)<br>Niagara: Amalgamation of *St. Catharines General, Greater Niagara General, Welland County General, Shaver, Douglas Memorial, Niagara on the Lake, Niagara Rehabilitation Centre,* and *Port Colborne General*<br>Metro Toronto: Amalgamation of *Addiction Research Foundation, Clarke Institute of Psychiatry, Donwood Institute, Queen Street Mental Health Centre*<br>Amalgamation of *Toronto Rehabilitation Centre, Rehabilitation Institute of Toronto* and *Lyndhurst Hospital*<br>Ottawa-Carleton: Amalgamation of *Ottawa Civic, Ottawa General, Riverside* and *Salvation Army Grace*<br>Sudbury: Amalgamation of *Laurentian Hospital, Sudbury General* and *Memorial* |
| [illegible] Shenk/ [illegible] Leonard | Metro Toronto: Transfer of operation and management of *St. Bernard's Hospital* to *St. John's Rehabilitation Centre* |
| [illegible] Steende | GTA/905: Amalgamation of *Centenary Health Centre* and *Ajax Pickering General* |
| [illegible] Watts | Northeastern Ontario: Creation of a governance structure for the new *Northeast Mental Health Centre.* |

## Figure IV-2: HSRC appointed governance facilitators

| FACILITATOR | TASK/PROJECT |
|---|---|
| Tim Armstrong | Haliburton, Kawartha, and Pine Ridge (HKPR): Assist with Board structure changes for the *Northumberland Health Care Corporation* |
| Paul Cramer/ Francine Pillemer | Metro Toronto: Amalgamation of *Orthopedic and Arthritic Hospital, Sunnybrook Health Science Centre* and *Women's College Hospital* |
| Michael Decter | GTA/905: Amalgamation of *Peel Memorial, Georgetown and District Memorial,* and *Etobicoke General*<br>Kingston: Investigate potential of an interim agreement between *Hôtel Dieu Hospital, Kingston General and Providence Continuing Care Centre* (working with A. Hudson) |
| Michael Delaney | Metro Toronto: Transfer of operation and management of programs and services of *Doctors Hospital* to *The Toronto Hospital* |
| Claude Halpin | GTA/905: Amalgamation of *Oakville Trafalgar Memorial* and *Milton General and District* |
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| Carolyn Sherk/ Louise Leonard | Metro Toronto: Transfer of operation and management of *St. Bernard's Hospital* to *St. John's Rehabilitation Centre* |
| Andrew Szende | GTA/905: Amalgamation of *Centenary Health Centre* and *Ajax Pickering General* |
| Michael Watts | Northeastern Ontario: Creation of a governance structure for the new *Northeast Mental Health Centre.* |

# Governance Facilitation – Lessons Learned

On October 13, 1999 the HSRC convened a meeting of all facilitators to discuss lessons learned from the processes they facilitated. The meeting was attended by most facilitators, expediting implementation of the HSRC's *Directions*, as well as representatives of the HSRC and its staff.

The HSRC thanks those who participated in the day's discussion. In particular, the HSRC is grateful to Mr. Bill Blundell, Director of Manulife Financial, for his counsel on the preparation and organization of the day's events, his leadership as Chair of the meeting, and to Professor Louise Lemieux-Charles (University of Toronto) for her guidance and for facilitating much of the meeting.

Participants were asked to reflect on their experiences and address three questions pertaining to the process they facilitated:

1. *What facilitated the process?*
2. *What hindered the process?*
3. *What lessons can be learned?*

In addition, participants were asked to comment on two issues:

1. *Given their role and experience as facilitators, was facilitation an effective mechanism to achieve agreement on hospital governance changes?*

2. *As health care restructuring evolves, how can future changes in health services governance be facilitated to support stronger vertical alliances among health care providers?*

### Key Observations

Based on the presentations made by facilitators it was evident that each had had different experiences depending on the process they were asked to facilitate.

Some were involved in processes characterized by an environment of agreement where the final objective was "amalgamation" of two or more parties. In these cases, those involved devoted their efforts to addressing pragmatic issues related to representation and process for establishment of the new governance structure. Others were faced with hostile parties and had to dedicate much time and effort to ensuring that the process itself could overcome the hostilities, before dealing with more pragmatic issues. While a number of factors affected the facilitation processes, the most common and significant related to these *environmental* factors, and/or *local issues and circumstances*. The latter two had the greatest impact on the outcome of the process, local acceptance and pace of implementation of the outcome.

The establishment of the HSRC by the provincial government, as an arms-length body responsible for issuing legally-binding *Directions* related to hospital restructuring, created an environment in which there was general agreement that the "status quo" of hospital governance and management would be affected. This allowed the facilitators to position the local process as an expectation that change *would* occur.

The 'neutral' role of the facilitators was noted as a positive factor for facilitating local governance discussions. Most of the facilitators were appointed by the HSRC from a list of candidates recommended by the hospitals themselves. The facilitators had the advantage of operating at arms-length from the HSRC, and being accountable to the HSRC and the hospitals for their role in the facilitation process. It was noted, however, that notwithstanding efforts to maintain their neutrality, some hospitals viewed the facilitators as a force imposed on them by the HSRC,

or as agents acting on behalf of the HSRC. In those situations the facilitators noted that their relationship with affected hospitals were often strained and confrontational.

Some facilitators noted that a key element of the terms of reference that helped the process significantly was their ability to make recommendations to the HSRC in the absence of agreement among the parties. In other words, the hospitals were aware that should the negotiations "get stuck" on critical issues, the HSRC could ask the facilitator for his/her recommendation(s) on how to resolve them, and would then consider the facilitator's advice in issuing additional *Directions*.

On the other hand, some facilitators voiced concern that their ability to recommend solutions to the HSRC made some hospitals less open to reaching compromise locally, and were therefore, hesitant to discuss issues with the facilitator, and more prone to deferring issues to the HSRC for resolution. This was evident particularly in processes where those who saw themselves as "potential losers" (if a compromise solution was reached) chose not to accept the "solution" until directed to do so by the HSRC.

A few facilitators mentioned that if had they been given the opportunity to work more closely with HSRC staff in shaping the *Directions* to meet local circumstances, there may have been a better outcome. However, others argued that maintaining an arms-length relationship with the HSRC and the MOHLTC helped establish and maintain their neutrality and independence.

Facilitators were divided on whether the HSRC's terms of reference for facilitation were appropriate. Some noted that the lack of specificity concerning the facilitation process and expected governance structure was helpful in allowing "wiggle room" to design local solutions for achieving the HSRC's *Directions*. This gave the parties the opportunity to design governance structures and processes consistent with local needs and expectations. Others noted that the terms of reference limited their ability to look beyond the hospital governance task and discuss broader issues of system integration and the role of (and their relationships to) other health providers.

Local issues and circumstances were key factors affecting facilitation. In those communities where hospital boards had not been successful in the past in establishing formal linkages and integrating structures with other hospitals, the HSRC's *Directions* were seen as an opportunity to achieve those objectives. In these communities (and in cases where local hospital leadership supported the *Directions*), the facilitation process moved quickly to establish the new governance and management structures.

Some of the key success factors identified in promoting acceptance of the development of a new governance structure and expediting its implementation included the ability to:

- Find local solutions for an orderly transition from the previous governance structures to the new amalgamated organization
- Develop evolutionary instead of revolutionary solutions, and
- Validate and respect existing board, management and medical staff leadership.

In communities where the relationship among hospitals was characterized by antipathy, rivalry and distrust, facilitation initially involved developing processes to address relationship barriers. Historical issues and relationships, in particular, played a role in slowing down and/or derailing the progress of governance discussions, especially in cases where there were years of apathy or hostility. Where there had been previous negative experiences and new partners

were proposed, the merger was welcomed. Where there was a perception that previously valued contributions of a merging partner were not being acknowledged the process was slowed down. The opposition to HSRC *Directions* by some hospitals, the aggressive stance by others and concern by small hospitals about being taken over (particularly in situations where large and small hospitals were directed to amalgamate) delayed the process and created trust issues among the parties.

There was general consensus that once the local facilitation process was started, the HSRC's "intransigence" (firmness) in backing the work of the facilitator, kept the process moving and ensured the parties remained at the table. The HSRC refused to negotiate with the parties while the facilitation process was under way and would not meet with individual hospitals on issues other than those related to the facilitation process. In these circumstances, it did so only when the meeting request was supported by the facilitator. Another contributing factor that supported the HSRC's "intransigence" was the government's firm position that it would not interfere in the arms-length mandate and work of the HSRC and/or its decisions.

Timelines were noted both as a positive and negative factor. Some noted that the short time frame kept the facilitation process moving and the parties focused on the tasks necessary to achieve the governance changes. Others noted that the tight timelines prevented engaging the parties in broader discussions about service integration beyond hospitals. Further, the short time frame made it difficult to build trust, address relationship issues between the parties, and placed significant demands on the time commitments of volunteer trustees.

### Key Lessons

The lessons learned from the discussions are summarized below.

***Enabling conditions*** — The following conditions enabled a successful *process* and *outcome*:

- The legal authority of the HSRC
- The arms-length positioning and establishment of process from the HSRC
- The facilitators' neutrality
- The facilitators' ability to make recommendations to the HSRC when the parties could not agree and the tight timelines
- The HSRC's "intransigence" and the government's refusal to get involved in HSRC issues and decisions
- The provision of support by the HSRC at critical junctures as needed by the facilitator
- The negotiation of terms of reference for the facilitation process, including expectations and consistent and regular communication to all parties on progress and next steps (as agreed to by the parties early in the process).

***Diversity of process*** — Given the diversity of most communities, local issues and needs, one approach will not fit all scenarios. The facilitation process and structure needs to be flexible and strategically planned to achieve the required objective and, at the same time, accommodate local issues and circumstances, including the history of the parties and individual hospital representatives involved in the facilitation process.

***Mandate*** — There will always be questions raised about the perceived 'ambiguity' of the facilitation mandate, depending on each party's perspectives and objectives. However, there was agreement that the governance level is the appropriate one at which to approach and lead broad-based change. Hospital systems are complex and rely on a multitude and

variety of structures to promote change. In some communities, it was felt that the scope of the facilitation mandate should have gone beyond establishing a new hospital governance structure and addressed related health system issues, such as the impact of changes to long-term care services, through an integrated approach. It was noted that some parties wanted to look at how their new governance structure would "fit" into an integrated system but felt constrained by the facilitation mandate.

***Leadership*** — Facilitation requires a significant investment in time by volunteer trustees, senior managers and physician leaders who represent their organization. There needs to be recognition of the time commitment placed on these individuals and the critical role they play in the negotiation process.

***Role of facilitators*** — The facilitators' role varied and was affected by several factors including the significance of the issues, the degree of local agreement with, and acceptance of, the HSRC's *Directions*, the relationship between the parties, local issues and interests, and local perceptions of who was in a position of power and control. *Are facilitators responsible for achieving consensus/agreement, or simply imposing change?* To maintain momentum and focus, facilitators need to be able to control and manage all aspects of the facilitation process, including documentation and communication to the parties. It is critical that the facilitators' role be made clear to the parties at the start of the process; however, it should be recognized that complexity of the issues might not become evident until the process is under way.

## Lessons for Future Facilitation

It is anticipated that future governance changes will be carried out as part of broader vertical integration involving a variety of health care providers. Following are some of the lessons drawn from the hospital facilitation experience that could be applied broadly:

- Significant efforts will be required to lay the groundwork in the community on the need for change. Starting with governance as a first step may not be appropriate if communities and organizations have not been involved in restructuring discussions and do not expect significant change. Therefore, pre-planning and negotiations training for the parties that will enable them to communicate more effectively with one another, and time for local debate, may be required.

- Facilitation is a critical first step but challenges/ barriers need to be anticipated at the beginning, with alternate approaches identified, if needed. Given that various approaches are likely required for different communities, a strategy session with individual facilitators prior to any facilitation should be considered to assess the challenges involved. For example, anticipating events or announcements that might derail the process, or managing a highly politicized process where the fate of an organization is sealed yet the community opposes the decision, may require some "up-front" work.

- Searching for "buy in" may be unrealistic when closing facilities because existing governors may be unable to champion a new world immediately. In such cases, the goals of facilitation should focus on different types of processes.

- It is critical to determine how the process should move along the facilitation line, from project management to facilitation to arbitration. As the process moves towards arbitration there will likely be less buy in at the local level as the outcome is perceived as being imposed.

- Recognize that there are limits to how far individuals and organizations can move in short order. For example, time is needed to develop and accept a new vision and achieve board renewal once a new amalgamated organization is formed. Second tier governance may be a necessary interim step although it runs the risk of perpetuating the old way of doing things and creating major barriers where innovation is contemplated. Therefore, the advantage of a community-based interim solution will need to be weighed against the need for a more integrated approach.

# Section V: Reinvestments

## Non-Acute Services
## Capital Investment – Acute Hospital Sector
## Capital Investment in Non-Acute Sector
## One-Time Operating Costs

M121

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# SECTION V: REINVESTMENTS

The HSRC operated with the understanding that the 'system' would be stable financially. This reflected the government's commitment to maintain at $17 plus billion the funding of health care in Ontario. This commitment meant that there would be the opportunity to reinvest in alternatives to hospital services that offered comparable or improved outcomes at lower costs and/or to expand services that would address gaps or shortfalls in the current delivery system.

## Non-Acute Services

A key challenge confronting the HSRC was to determine where (and how much) reinvestment in community-based services (i.e., long-term care, home care) would be required to support the restructured hospital system. In fact, the question of what would be done with the 'savings' achieved from hospital restructuring was a concern raised frequently throughout the HSRC's mandate by providers and members of the public. Many feared that savings would be returned to the Treasurer of Ontario in spite of the government's widely communicated policy that the health care budget would not fall below the expenditure level at the time the current government assumed office in 1995. At that time, the provincial health care budget stood at approximately $17.4 billion. Over the next few years the budget grew to over $20 billion (see Figure V-1).

**Figure V-1: Ontario Health Budget (1995-96 - 1999-00)**

| | (Billions) |
|---|---|
| [illegible] | $17.4 |
| [illegible] | $17.718 |
| [illegible] | $17.845 |
| [illegible] | $18.682 |
| [illegible] | $20.173 |

A key factor contributing to the general skepticism and anxiety about reinvestment in the health system was the lack of parameters or guidelines to indicate *how much* should be reinvested in *what* services. To address this uncertainty and to begin to apply some rigor and consistency concerning needed reinvestments in its advice to the Minister of Health, the HSRC undertook a series of research initiatives to guide the rebalancing of health services among hospitals, home care, long-term care and other services. These projects focused on addressing the following questions:

- *How much service, service reallocation and/or reinvestment are required in relation to local population health requirements?*
- *What is the type of service(s) required?*
- *What policy levers are required to ensure transition to the identified targets based on the planning guidelines?*

On a community by community basis, the objective was to apply the planning guidelines to determine the most appropriate areas of reinvestment.

In July 1997, the HSRC released the initial draft of its proposed planning guidelines in a discussion paper titled, *Rebuilding Ontario's Health System: interim planning guidelines and implementation strategies.*[26] The paper provided an overview of a series of projects undertaken by the HSRC to develop planning guidelines for home care, long-term care, mental health, rehabilitation and sub-acute care. Guidelines determined future capacity and service levels (resource requirements to 2003) and/or the reinvestments necessary to support a restructured health system.

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One of the surprising issues discovered by the HSRC at the outset of this project was the absence and/or currency and reliability of good data and information. While Ontario benefited from a comprehensive and reliable hospital in-patient database, the same did (and does) not hold true for data related to the other components of the health system. It therefore became clear that one of the biggest obstacles to be overcome in developing the guidelines related to the data limitations inherent in current databases.

The final recommendations offering advice to the Minister on guidelines for reinvestment were released in a subsequent paper, *Change and Transition: planning guidelines and implementation strategies for home care, long-term care, mental health, rehabilitation, and sub-acute care.*[27] Figure V-2 outlines the specific objectives for each of the major projects as well as the final planning guidelines used by the HSRC in determining appropriate reinvestments. These guidelines served as the basis for:

- Preparing *Notices/Directions* related to the sizing of complex continuing care (formerly chronic care), rehabilitation, and sub-acute care in-patient services
- *Advice to the Minister of Health* regarding mental health
- *Advice to the Minister of Health* related to restructuring the other components of the health system reviewed.

It is important to note that the MOHLTC did not embrace the concept of identified funding for sub-acute beds. Rather, on January 8, 1999, in correspondence to public hospitals in Ontario, the MOHLTC confirmed the following:

> *The Ministry's policy on sub-acute care reinforces that sub-acute care falls within the acute care continuum, and does not require a separate category of beds, with separate funding outside of the hospital's global budget. The Ministry's policy is that sub-acute care is, to some degree, already being provided and will continue to be provided by hospitals through their global budget as part of their ongoing, acute in-patient services delivery. As such the Ministry accepts the bed allocations as directed by the HSRC. In keeping with the Ministry's policy these beds will be classified as "acute" care within existing hospital reporting systems. Funding will be determined as part of the overall acute care budget for the individual hospital.*

**Figure V-2: Reinvestment research projects – objectives, results and key advice**

| Project Objective(s) | Results/Planning Guideline(s) | Key Advice for Implementation of Reinvestment Guideline(s) |
|---|---|---|
| **Home Care[28] (HC)**<br><br>***To study the effects of home care utilization as related to best practice hospitals in average length of stay (ALOS) and day surgery.*** | The proposed home care methodology based on the 25th percentile rate is to be used to determine required reinvestment in each Home Care Program.<br><br>Using algorithm and factoring in growth to the year 2003, an estimated $164.9 million reinvestment is needed for acute home care [post same day surgery or in-patient discharge]. | • MOHLTC to reconcile the reinvestment proposed by the HSRC for each HC program with the funding adjustments already made by the Ministry.<br>• MOHLTC to work with CCACs to develop an accountability framework for implementation of the reinvestment.<br>• MOHLTC to assess current funding levels to community support services. |

[27] HSRC. *Change and Transition: planning guidelines and implementation strategies for home care, long-term care, mental health, rehabilitation, and sub-acute care.* April 1998.

[28] For the purposes of the HSRC, (post-acute) home care was defined as health care services provided in patients' homes within 30 days following an in-patient or same day surgery discharge.

| Project Objective(s) | Results/Planning Guideline(s) | Key Advice for Implementation of Reinvestment Guideline(s) |
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| **Complex Continuing Care (CCC)**<br><br>*To determine an appropriate role for chronic care hospitals and units within the LTC continuum and develop a framework for restructuring chronic hospitals and units.* | 'Chronic care' is redefined as complex continuing care and a planning guideline of 8.23 beds/1,000 population (75+) is proposed. | • CCC to be an integral component of the LTC sector.<br>• The benchmark will not be achieved "overnight"; careful co-ordination and planning is required with other components of LTC sector.<br>• There is need for the immediate substitution of LTC beds to compensate for decrease(s) in CCC beds.<br>• Admission to chronic care hospitals/units for complex continuing care should be restricted to those whose needs require hospital care.<br>• There should be a single and consistent process for assessing needs and determining eligibility. The funding system for LTC (including complex continuing care) should be unified and funding levels determined in relation to the *needs* of the residents regardless of the venue of care. |
| **Long-Term Care 'Beds'**<br><br>*To develop a planning model that identified the total "need" for long-term care services including a planning guide for facility-based services (as part of the total need for services).* | The proposed model for determining "minimum LTC bed" numbers (for nursing homes/homes for the aged – NH/HFA) used the 25th percentile (1st quartile) utilization rates for each individual age/gender cohort as the minimum standard (i.e. 25th percentile actual utilization of NH/HFA* beds per population by age and gender group as a minimum standard for bed availability).<br><br>**Bed planning model** = 99.1 NH/HFA beds per 1,000 (75+) [2003]. Using the revised planning model, it is estimated that 40.9 per cent of the required 41,388 LTC places should be provided as NH/HFA beds. (i.e., of the 41,338 places, 16,920 NH/HFA beds should be used as a planning guide with the additional 24,468 being provided as non-bed places). | • The bed/place benchmarks are not "absolute targets" but should be considered guidelines for achieving the right balance/mix of LTC services. |

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The HSRC's advice to the government on implementation of the proposed guidelines was intended to promote greater integration between and among the sectors. For example, the recommended establishment of rehabilitation networks was expected to bring providers of this service together, as well as to address a number of issues concerning the delivery of rehabilitation services, including the need for better information systems and patient outcome data.

Similarly, the significant realignment required to accommodate shifts in the long-term care system (including the redefinition of chronic care as complex continuing care, the elimination of ALC beds and the reinvestment in long-term care beds/"places") was expected to demand stronger co-ordination and linkages across the current system.

On April 28, 1998 the government announced its commitment to reinvest $2 billion in home care and institutionally based long-term care. This announcement was welcomed by the HSRC particularly because it addressed directly the long-standing concern of the Commission and the health sector over whether reinvestment would, in fact, occur.

As was known from the outset, hospital restructuring and reinvestment in other services, including long-term care, had to go together. It was important that the whole restructuring process was not perceived by the public to be focused on saving money but rather on creating a balanced and organized system of health services. Early in the HSRC's mandate there was a lot of energy and a high degree of enthusiasm and optimism among many providers in the health system that after years of discussion and debate change would finally happen. This impetus helped the HSRC gain respect within the provider community, and a certain degree of 'acceptance' by the public. In all of the HSRC's restructuring reports emphasis was placed on the need for reinvestment in home care, long-term care, mental health and other sectors of the health care system to coincide with hospital restructuring. However, the long gap in time between the release of the HSRC's *Directions* and follow-up by the MOHLTC on the required reinvestments contributed, in large part, to a loss of momentum part way through the HSRC's mandate. Fortunately, the government's announcement in 1998 that 20,000 new LTC facility beds would be opened over a six-year period (as part of the

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Similarly, the significant realignment required to accommodate shifts in the long-term care system (including the redefinition of chronic care as complex continuing care, the elimination of ALC beds and the reinvestment in long-term care beds/"places") was expected to demand stronger co-ordination and linkages across the current system.

On April 28, 1998 the government announced its commitment to reinvest $2 billion in home care and institutionally based long-term care. This announcement was welcomed by the HSRC particularly because it addressed directly the long-standing concern of the Commission and the health sector over whether reinvestment would, in fact, occur.

As was known from the outset, hospital restructuring and reinvestment in other services, including long-term care, had to go together. It was important that the whole restructuring process was not perceived by the public to be focused on saving money but rather on creating a balanced and organized system of health services. Early in the HSRC's mandate there was a lot of energy and a high degree of enthusiasm and optimism among many providers in the health system that after years of discussion and debate change would finally happen. This impetus helped the HSRC gain respect within the provider community, and a certain degree of 'acceptance' by the public. In all of the HSRC's restructuring reports emphasis was placed on the need for reinvestment in home care, long-term care, mental health and other sectors of the health care system to coincide with hospital restructuring. However, the long gap in time between the release of the HSRC's *Directions* and follow-up by the MOHLTC on the required reinvestments contributed, in large part, to a loss of momentum part way through the HSRC's mandate. Fortunately, the government's announcement in 1998 that 20,000 new LTC facility beds would be opened over a six-year period (as part of the

MOHLTC's Multi-Year Plan) helped combat the general cynicism and put a balanced perspective on the HSRC's and the Ministry's work to restructure/ create a system.

However, the HSRC remains concerned at the conclusion of its mandate that continued slowness in the pace of reinvestments will jeopardize the success of the restructuring process and result in the loss of (or at least greatly diminish) the gains made to improve the health system. In addition, it is crucial to monitor the impact of new reinvestments (i.e., long-term care beds, home care, reductions/redistribution of mental health and rehabilitation services) related to the overall system requirements to ensure:

- That public policy and expenditures are evaluated as the LTC, home care, and rehabilitation sectors proceed with implementation according to a multi-year plan.
- The orderly downsizing and closure of beds in the (previous) chronic care system.
- Expediting the adoption of the MDS classification system across the LTC system.
- Expansion of CCACs role to control access to complex continuing care beds as is currently done for access to LTC facility beds.
- A strong link between the closure of hospital beds and opening of new long-term care beds.

## Capital Investment - Acute Hospital Sector

In the absence of provincial policies and investment strategies, the HSRC approached the issue of capital investment on a community by community basis. Investment in capital was perceived by the HSRC to be critical to achieving full restructuring and realizing cost savings.

Capital estimates required to support restructuring were considered in the HSRC's analysis under the criteria of affordability. While they were important considerations, decisions on capital investment were not driven by or predicated upon cost 'cuts' or 'savings'. In particular, requirements for capital investment were evaluated based on a number of considerations including:

- the short-term pay-back period and savings generated relative to the capital investment
- the availability, adequacy and future usefulness of existing capital stock
- the potential for achieving current standards in acute care, chronic care, rehabilitation and mental health

The HSRC also recognized that there were other long-standing capital needs that were in addition to what was required to consolidate capacity. Throughout the HSRC's mandate repeated concerns were expressed about the issue of capital in three key areas:

1. The adequacy/sufficiency of capital estimates contained in the HSRC's advice to the Minister.[30]
2. Delay in announcement of its availability in some communities that had received HSRC final *Directions*.
3. Slowness on the part of the Ministry in proceeding through the functional planning/review phase concerning capital requirements to the implementation phase.

On a number of occasions, the HSRC urged the MOHLTC to make and release decisions regarding capital investments to assist in expediting health services restructuring initiatives across the province. Of particular concern was the need for the Ministry to streamline its capital approval process including processes at the 'centre'.

[30] Throughout the HSRC's mandate disputes arose concerning the adequacy of the HSRC's proposed capital reinvestments. Many of the disagreements stemmed from different interpretations regarding the capital costs associated with restructuring as noted by the HSRC versus additional costs identified by the community(ies) related to renovation versus renewal versus new construction.

**Figure V-3 : HSRC recommended capital investment**

| [illegible] | $ in millions | Community | $ in millions |
|---|---|---|---|
| [illegible] | 83 | Hamilton | 77 |
| [illegible] | 87 | Brant | 43 |
| [illegible] | 42 | Kingston | 108 |
| [illegible] | 8 | Hastings & Prince Edward | 42 |
| [illegible] | 215 | Haliburton, Kawartha and Pine Ridge | 81 |
| [illegible] | 318 | Cornwall | 17 |
| [illegible] | 140 | Waterloo | 55 |
| [illegible] | 110 | Parry Sound | 29 |
| [illegible] | 42 | North Bay | 111 |
| [illegible] | 24 | Niagara | 99 |
| [illegible] | 314 | Sault Ste. Marie | 46 |
| [illegible] $2.1 Billion<br>[illegible] $1.3 Billion (see discussion that follows) | | | |

The slowness in moving through the capital approval process in the MOHLTC resulted in a loss of patience and confidence by those in the broader community and threatened the very success of restructuring. The bottom line, however, is positive. The HSRC recommended a total of approximately $2.1 billion on capital development projects involving 96 hospital sites. As of February 2000, the MOHLTC had approved 58 projects valued at $1.6 billion on 40 sites in support of restructuring. Some of the 58 projects are for "headstart" projects. That is, pieces of larger projects that are proceeding ahead of the main contract to accommodate, for example, the early expansion of emergency departments. This represents the largest single investment in new and renovated buildings and equipment in Ontario's history.

In 1997-98, the Minister of Finance[31] announced the following capital funding policies to facilitate the implementation of hospital restructuring and the *Directions* and *Advice* provided by the HSRC. The details of the announcement are included in Figure V-4.

A report[32] prepared by Enterprise Canada Research for the Ontario Hospital Association in April 1999 reviewed some of the key issues related to the capital financial needs of Ontario's hospitals. The report estimated capital financial needs of approximately $7.8 billion over the 1999-2003 period with capital costs directly attributable to implementation of *Directions* from the HSRC accounting for 40 per cent of this amount ($3.2 billion); other redevelopment and capital projects require $3.1 billion.

[31] In the 1997-98 Provincial Budget, the Minister of Finance announced that over the next five years, $2.7 billion would be invested in the restructuring of the province's heath care system. The announcement indicated that the province would provide 85 percent of eligible operating costs and up to 70 percent of capital expenses to address "eligible, one-time operating and capital costs required to implement restructuring initiatives."

[32] Enterprise Canada Research. Interim report capital needs study. A report prepared for the Ontario Hospital Association, April 6, 1999.

**Figure V-3 : HSRC recommended capital investment**

| Community | $ in millions | Community | $ in millions |
|---|---|---|---|
| Thunder Bay | 93 | Hamilton | 77 |
| Sudbury | 87 | Brant | 43 |
| Lambton | 42 | Kingston | 108 |
| Pembroke | 6 | Hastings & Prince Edward | 42 |
| London | 215 | Haliburton, Kawartha and Pine Ridge | 81 |
| Toronto | 318 | Cornwall | 17 |
| Ottawa | 140 | Waterloo | 55 |
| Essex | 110 | Parry Sound | 29 |
| Kent | 42 | North Bay | 111 |
| Brockville | 24 | Niagara | 99 |
| GTA/905 | 314 | Sault Ste. Marie | 46 |
| Total for above communities: $2.1 Billion | | | |
| LTC facility beds: $1.3 Billion (see discussion that follows) | | | |

The slowness in moving through the capital approval process in the MOHLTC resulted in a loss of patience and confidence by those in the broader community and threatened the very success of restructuring. The bottom line, however, is positive. The HSRC recommended a total of approximately $2.1 billion on capital development projects involving 96 hospital sites. As of February 2000, the MOHLTC had approved 58 projects valued at $1.6 billion on 40 sites in support of restructuring. Some of the 58 projects are for "headstart" projects. That is, pieces of larger projects that are proceeding ahead of the main contract to accommodate, for example, the early expansion of emergency departments. This represents the largest single investment in new and renovated buildings and equipment in Ontario's history.

In 1997-98, the Minister of Finance[51] announced the following capital funding policies to facilitate the implementation of hospital restructuring and the *Directions* and *Advice* provided by the HSRC. The details of the announcement are included in Figure V-4.

A report[52] prepared by Enterprise Canada Research for the Ontario Hospital Association in April 1999 reviewed some of the key issues related to the capital financial needs of Ontario's hospitals. The report estimated capital financial needs of approximately $7.8 billion over the 1999-2003 period with capital costs directly attributable to implementation of *Directions* from the HSRC accounting for 40 per cent of this amount ($3.2 billion); other redevelopment and capital projects require $3.1 billion.

[51] In the 1997-98 Provincial Budget, the Minister of Finance announced that over the next five years, $2.7 billion would be invested in the restructuring of the province's heath care system. The announcement indicated that the province would provide 85 percent of eligible operating costs and up to 70 percent of capital expenses to address "eligible, one-time operating and capital costs required to implement restructuring initiatives."

[52] Enterprise Canada Research. Interim report capital needs study. A report prepared for the Ontario Hospital Association, April 6, 1999.

**Figure V-4 : MOHLTC Capital funding policies to facilitate restructuring**

| | |
|---|---|
| **Public hospital capital funding** | 70 per cent funding of eligible capital and related costs (beginning in 1996-97) to support restructuring. Capital costs incurred as a result of the implementation of the MOHLTC *approved capital plan* eligible for reimbursement from the MOHLTC include:<br><br>**Fees:** fees for architects, cost consultants, functional programmers and planning consultants (as defined by the Ministry's capital planning process)<br><br>**Construction and related costs:** renovation work; new construction; site development; building permits, commissioning, legal, tender advertisements; other miscellaneous costs, as defined by the Ministry's capital planning manual; demolition and decommissioning associated with the site of the required new construction; project management; cash allowances for specific purposes; new furnishings and equipment (not replacement equipment) |
| **Mental health capital funding**[33] | 100 per cent funding of eligible capital costs for forensic mental health programs and services directed by the HSRC to be transferred from a PPH to a public hospital;<br><br>100 per cent funding of eligible capital costs for non-forensic mental health programs and services directed by the HSRC to be transferred from a PPH to a public hospital;<br><br>70 per cent funding of eligible capital costs for the expansion, merger or relocation (transfer) of non-forensic mental health programs and services from one public hospital to another, as per capital funding policies for HSRC *Directions*.<br><br>Once mental health programs and services have been established in public hospitals, as per the *Directions* and advice of the HSRC, future capital projects affecting those programs and services will be cost-shared as follows:<br><br>Approved non-forensic mental health capital projects funding according to the prevailing capital policy of the time (the current MOHLTC capital policy provides for 50 per cent funding of eligible capital costs for projects that are not directed by the HSRC but meet current capital funding criteria). |

The balance ($1.4 billion) was estimated to be the requirements for investment in information technology. Two of the major issues emerging from this report were as follows:

- There is a substantial gap between the need for capital and communities' ability to raise capital locally. In particular, from a financing perspective, the non-restructuring costs are as great a challenge as restructuring.
- A successful approach to managing capital needs in the hospital sector will require a strategy to address the "cash flow" problem associated with restructuring. In short, most of the costs will be incurred before the funds can be secured from fund-raising or other revenue generation techniques.

[33] Correspondence to public hospitals, provincial psychiatric hospitals, specialty psychiatric hospitals from the MOHLTC, January 14, 1998.

THE HSRC continues to be concerned about the ongoing discussions between individual hospitals and the MOHLTC concerning 'appropriate' levels of capital funding. Many of the negotitations currently under way are based on controversies over what capital requirements are needed to support restructuring — versus renovation — versus renewal, etc.

It is important to recognize that the HSRC confined itself to estimating the capital costs associated with restructuring. The government's commitment to invest in capital renewal to support restructuring of the health system opened the door for virtually everyone to push as much as they could to maximize their 'take' — that for some (eg. Thunder Bay and Cobourg) led to approval by the goverment to build new hospitals.

## Capital Reinvestment in Non-Acute Sector

The need for capital reinvestment in other sectors of the health system was also acknowledged by the HSRC as critical to the restructuring process. At the time of the HSRC's establishment, for example, there was little capacity to expand quickly long-term care services in many regions. Successful implementation of the long-term care planning guidelines (beds and places) will require the upgrading of existing facility stock as well as expansion and/or construction of new facilities. Therefore, the HSRC recommended that:

- The MOHLTC announce its decisions regarding the design standards and implementation of a capital funding strategy for LTC facilities to ensure sufficient resources for the building of new LTC beds and the upgrading/retrofitting of existing facilities. This was an issue that the MOHLTC had been working on for a number of years.
- The MOHLTC evaluate the physical status of currently available nursing homes and homes for the aged to determine their suitability to accommodate higher-need, more complex care residents.

The capital investment required to support the construction of 16,920 new LTC beds,[34] as recommended by the HSRC in their planning document, *Change and Transition*, would result in a total investment of approximately $1.3 billion.[35] It is important to note, however, that the HSRC recommended a phased-in approach to the proposed increase in LTC facility beds. The HSRC bed guideline was intended to be used only as a guide for planning. As a starting principle, the HSRC recommended that reinvestment in new LTC beds be linked directly to changes in acute and complex continuing care hospitals.

Thus, the immediate need for reinvestment in the LTC facility sector was to ensure that there would be sufficient capacity to replace reductions in beds in other parts of the health care sector.

## One-Time Operating Costs

In all of its restructuring reports, the HSRC acknowledged that there would be a series of one-time costs associated with hospital restructuring including such things as: purchase of capital equipment, demolition and decommissioning costs, and labour adjustment costs. While it was recognized that hospital foundations and/or working capital funds may be able to fund a portion of these expenses, the HSRC recommended that the MOHLTC contribute a portion as well.

[34] At the time of the HSRC's closure, 6,700 of the total (20,000) LTC beds that were awarded by the Government had been awarded with another 5,700 in the midst of the RFP process. As of February 2000 none of these beds were constructed.

[35] This was calculated based on the following formula: total # of beds X $10.35/day X 365 days per year X 20 years.

The provincial government announced in 1997-98 that it would provide support for hospitals that were eligible for reimbursement of incurred restructuring expenses (beginning in the fiscal year 1996-97). These costs included one-time operating expenses associated with restructuring such as, severance costs, counseling and training costs, communication costs, legal fees, consulting and auditing.

Assessment of reimbursement for restructuring costs were based on the following priorities:

- Restructuring plans must be approved by the Board of Directors of the hospital, and be consistent with the *Directions* of the HSRC or local DHC restructuring study.
- The cost must be part of a restructuring component within the Operating Plan approved by the Board.

# Section VI:
# Mental Health Reform

HSRC

# SECTION VI: MENTAL HEALTH REFORM

Restructuring and reinvesting in the mental health sector warrants special discussion given the significance of mental health services to the well-being of Ontarians. It is particularly sensitive given the concerns of the Commission and others in the province who remember the "disastrous" attempts to revamp the system in the early 1970s when the PPHs were "downsized" without adequate preparations being made to provide the patients who were displaced with necessary community-based services (and especially accommodation).

Throughout its mandate the HSRC voiced its support for three premises governing provincial mental health reform:

1. That an envelope of funds exclusively for mental health services be created.

2. That this envelope be protected (or expanded) and that resources 'saved' from institutional restructuring be reallocated to community and other mental health services.

3. That community supports be in place prior to the closure of beds in PPHs.

The starting point for the HSRC in planning capacity for in-patient mental health services was the proposed ratios outlined in the MOHLTC policy document, *Putting People First* (1993). This document proposed a target bed ratio of 30 mental health beds for every 100,000 (adult population) in the province by 2003. Sixty per cent of these were to be allocated for acute in-patient mental health (16 beds/100,000) and 40 per cent to longer term mental health (14 beds/100,000).

All of the communities that were issued *Notices of Intention to Issue Directions* during the first few months of the HSRC's mandate considered the planning target to be "too ambitious". In particular, there were concerns that it would not allow sufficient time and flexibility to achieve this shift without putting access and quality at risk. Another concern was that appropriate community supports would not be in place in sufficient time to meet patient needs resulting from the closure of mental health beds.

In response to these concerns the HSRC undertook an internal review of the planning guideline. While the HSRC agreed that the 30 beds per 100,000 target was an appropriate benchmark to work toward, it suggested that the following interim targets be applied for hospital-based mental health bed planning:

- By the year 2000: 37 beds per 100,000 (adult) population including 21 beds per 100,000 for acute mental health beds and 16 beds per 100,000 for long-term mental health.

- By the year 2003: 35 beds per 100,000 (adult) population including 21 beds per 100,000 population for acute mental health and 14 beds per 100,000 for longer term mental health beds.

These guidelines were released in the discussion paper, *Rebuilding Ontario's Health System* (see Section V for a more complete discussion of this document).

Throughout its four-year mandate, the HSRC advocated the establishment of regional Mental Health Agencies (subsequently established by the MOHLTC as Mental Health Implementation Task Forces). This concept was introduced in the HSRC's first restructuring report issued in Thunder Bay in October 1996.[36] The advice to the Minister of Health was as follows:

> *That the Minister of Health establish by March 31, 1997 a Northwestern Ontario Mental Health Agency to operate within the provincial government's policy and fiscal framework. The Minister of Health should allocate to the Agency the funds provided by the Ministry for all mental health services including: the entire Lakehead Psychiatric Hospital budget, funding for the acute, forensic and adolescent beds to be located at the Thunder Bay Regional Hospital, funding for the psycho-geriatric/rehabilitation beds to be located at St. Joseph's General Hospital, and the resources currently allocated for community-based mental health services...The Agency will be accountable to the Minister for meeting the mental health needs of the residents of Northwestern Ontario.*[37]

These interim/transitional structures were envisioned as *devolved* decision-making structures responsible for co-ordinating and expediting provincial divestment of PPHs and facilitating restructuring within the mental health sector, as appropriate for each community/district/region. The original concept was to have these 'agencies' hold an envelope of funds. The HSRC eventually moved away from the fund-holding concept in the hope of securing the government's agreement to establish local, "on the ground", entities responsible for restructuring PPH services and resources. The HSRC repeatedly emphasized that the goal of PPH restructuring must be:

> *To create a local system of care that ensures access to a broad range of community-based and clinical service supports. The system should provide choices to persons with mental illnesses/disorders, allowing them to set and realize their personal goals, and acquire the skills and resources needed to achieve independence and well-being.*[38]

The HSRC frequently voiced its concern that the immediate priority for PPH communities/districts/regions must be to identify practical ways to facilitate "on the ground" implementation of PPH reforms to ensure local, co-ordinated systems of care for persons with mental illnesses/disorders. The HSRC recommended that Mental Health Implementation Task Forces (MHITF) be the local vehicle to catalyze this activity.

The slow pace of divesting provincial ownership and management of PPHs and the realignment of services associated with this process continues to be a major barrier to implementing local restructuring in those communities where the HSRC advised the Minister to divest PPH operations and management. As previously noted, the HSRC submitted additional formal advice to the Minister of Health in February 1999 to heighten awareness of the issues contributing to the slow progress in restructuring PPHs. The document, *Advice to the Minister of Health on Building a Community Mental Health System in Ontario*, also outlined specific strategies to ensure appropriate systems are in place and monitored when PPHs divest their patients and ambulatory care

[36] The HSRC's Thunder Bay Restructuring Report (October 4, 1996) was the first to outline the HSRC's approach to mental health services. It was based on the assumption that in-patient service requirements could be reduced to 30 beds per 100,000 people (for the population 15 years and older) given appropriate investments in community-based services.

[37] HSRC Advice to the Minister, *Thunder Bay Restructuring Report*, October 4, 1996.

[38] The HSRC's advice on implementing PPH reform was consolidated and published in the document titled *Advice to the Minister of Health on Building a Community Mental Health System in Ontario*, February 26, 1999.

responsibilities to other community organizations (including public hospitals). Three primary issues were identified in the document:

i. Lack of local leadership to implement PPH restructuring
ii. Uncertainty about the reinvestment/service strategy and the level and timing of 'up front' investment available to facilitate PPH restructuring
iii. Difficulties in reaching agreement on labour mobility and adjustment plans [including related governance transfer agreements] at the local/regional level.

On March 12, 1999, the Minister of Health formally accepted the advice of the HSRC regarding the establishment of Mental Health Implementation Task Forces (MHITF), beginning in the Northeast. At the conclusion of the HSRC's mandate an additional Task Force was being established in the Northwest. It is anticipated that additional task forces will be established in other regions.

The unwillingness of the Ministry to act quickly to establish such Task Forces in each community/district/region containing a PPH, despite agreement to do so, remains the source of great frustration and concern. The fear is that people with mental health problems will, once again, be sacrificed on the twin altars of bureaucratic obscurantism and union protectionism. They deserve better!

# Section VII:
# Review of
# Rural/Northern Hospitals

HSRC

# SECTION VII: REVIEW OF RURAL/NORTHERN HOSPITALS

Of its three cardinal criteria, accessibility, quality and affordability, the issue of accessibility was of particular concern to the HSRC in considering the implications of hospital restructuring in rural and northern Ontario.

Early in its mandate, the HSRC decided that it would focus initially on restructuring hospitals in larger urban areas (particularly cities with two or more hospitals) given their significant resource base. At the same time, the HSRC acknowledged that hospitals located in rural and northern communities faced a series of particular challenges or conditions attributable to less densely populated and isolated areas. These challenges include:

- Distances to health care services, particularly specialized services that are located in regional centres;
- Low patient volumes posing difficulties in ensuring appropriate critical mass of programs and services necessary to achieve quality and retain the necessary resources and expertise; and,
- Recruitment and retention of physicians and other health professionals.

Furthermore, benchmarks applied in urban areas were not applicable given the nature, volume and scope of activities carried out in rural and small northern communities.[39] Consequently, the HSRC was clear from the outset that the approach to restructuring hospitals in rural/northern regions of the province would be different from that used for urban areas.

The HSRC articulated two underlying principles to govern its review of rural/northern hospitals. These were:

1. The primary goal of restructuring hospitals in rural and northern communities is to ensure that each of the *networks*[40] will provide optimum *accessibility* to the highest possible *quality* of hospital-based services in the most *cost-effective* way for the population in all communities served by the member hospitals.[41]

2. Hospital closures are probably neither desirable nor feasible. However, there are savings to be derived through clinical and administrative efficiencies that can be redirected to the maintenance and, where possible, enhancement of patient care programs and services.

The issues associated with the appropriate roles of rural hospitals in a restructured health system, and how these issues should be dealt with by the HSRC, first came to the fore during the HSRC's review of hospitals in Lambton and Renfrew counties. The HSRC's review prompted the MOHLTC to develop a policy framework to help guide the HSRC with respect to its work on rural hospitals.

[39] Key challenges that have dominated discussions related to health services in rural and northern areas include: the shortage of physicians and other health professionals; difficulties in ensuring access to emergency health care and regional/centralized programs provided at tertiary and secondary referral centres; and, the availability and quality of specialty services primarily related to obstetrics, surgery, and mental health care.

[40] MOHLTC[1997]. *The Rural and Northern Health Care Framework* used the term regional to describe a system of "networks" or "clusters" called Rural and Northern Health Care Networks. The framework proposed that hospitals should be formally linked through these networks.

[41] The objective is not to reduce overall expenditures on hospital services within each hospital network but to improve the quality of services within the area served by the network and derive savings from clinical and administrative efficiencies that can be redirected to patient care.

The *Rural and Northern Health Care Framework* was issued by the MOHLTC in June 1997.[42] The framework informed the HSRC's subsequent review of rural/northern hospitals. The framework articulated guidelines for DHCs, hospitals, community-based service providers and the MOHLTC in planning for restructuring within a health care network that would help facilitate 24-hour access to services. The initial priority was the development of hospital networks. The longer-term priority was to establish a series of health care networks that would eventually involve community-based providers.

The HSRC's work in several communities, which included one or more rural hospital sites, has been consistent with the concept of linking rural and northern hospitals in networks. For example, hospitals in Lambton County were directed to establish a joint executive committee (JEC) with a mandate to oversee the delivery of hospital services to the communities served, co-ordinate, consolidate and streamline services and administrative functions, and establish a single administrative and clinical leadership structure. Similar linkages and relationships were directed for hospitals in Kent County and in Haliburton, Kawartha and Pine Ridge Counties. In the communities of Durham and Niagara[43], rural hospitals were directed to amalgamate with other hospitals (including urban sites) to form a single hospital corporation. Thus, the establishment of JECs (or amalgamations) involving rural and northern hospitals has been an effective way of formalizing relationships for the delivery of health care services.

The HSRC began its review of the balance of rural/northern hospitals in June 1998. The first step was to identify the member hospitals of rural networks (each to include at least one secondary referral hospital). The HSRC based its development of the proposed networks on an analysis that considered where patients live, where patients use local services and where they are referred for access to secondary and tertiary services. Formal relationships among hospitals were also considered. The HSRC held information sessions for hospitals and DHCs to allow for discussion of the HSRC's proposed review process.

It was anticipated that establishing linkages and relationships between hospitals within a network would lead to improved co-ordination and information-sharing among them. Specifically, the establishment of stronger linkages and relationships was expected to help achieve the following objectives:

- Effective integration/co-ordination in hospital care services delivery
- Easier access by individuals and families to the most appropriate level and form of health care related to their needs
- High quality health services in an environment that fosters the pursuit of excellence
- Assessment of current hospital services and identification of new or revised ways to deliver improved programs and/or address unmet community needs

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[42] The *Rural and Northern Health Care Framework* (June 1997) laid the foundation for the HSRC's work and was followed by a second document released by the MOHLTC in July 1998 titled *Rural and Northern Health: Parameters and Benchmarks Report.* Prepared by a Joint Committee of the MOHLTC and the OHA, the second report involved collaboration among the OMA, the Registered Nurses Association of Ontario, and DHCs. It presented a set of tools and a planning methodology to assist DHCs, hospitals and other providers to begin the work of implementing networks.

[43] In November 1999, the Ontario Superior Court of Justice dismissed an application of the Douglas Memorial Hospital (Niagara region) to quash the *Directions* issued by the HSRC. The judgement found that the Commission was not bound by the Framework in making decisions on hospital restructuring and had not exceeded its jurisdiction in replacing the governing board of Douglas Memorial Hospital with a standing committee in a larger governing body.

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- Progressive human resource policies developed in co-operation with professional associations, unions and volunteers, recognizing that the network's most important resource is its human capital
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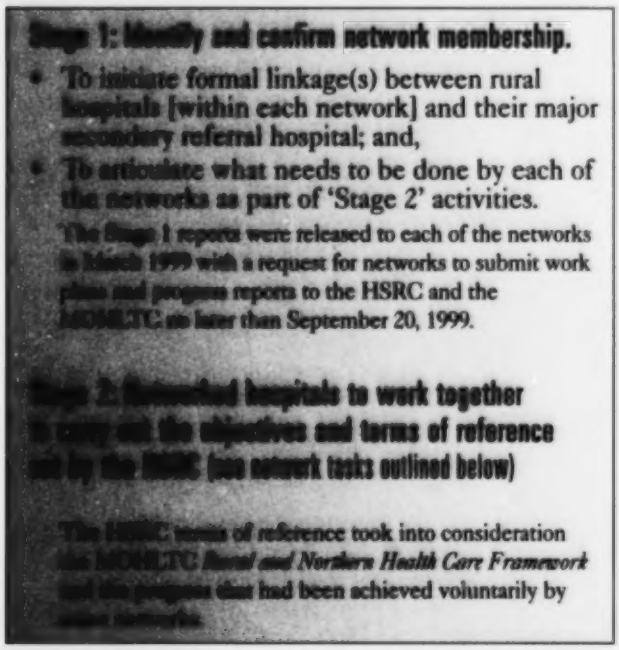
Though the HSRC had initially intended on issuing *Notices of Intention to Issue Directions* (followed by final *Directions*) to hospitals in the rural/northern networks, the regulatory changes made by the government in April 1999 prohibited the Commission from issuing any further *directions*. The HSRC's duties were changed such that it was in a position only to provide advice to the Minister of Health (see Appendix B for further discussion of regulatory changes — Ontario Regulations 272/99 and 273/99).

As a result, the HSRC amended its process as follows:

**Figure VII-1: HSRC approach to rural/northern networks**


Stage 1: Identify and confirm network membership.
• To initiate formal linkage(s) between rural hospitals [within each network] and their major secondary referral hospital; and,
• To articulate what needs to be done by each of the networks as part of 'Stage 2' activities.
The Stage 1 reports were released to each of the networks in March 1999 with a request for networks to submit work plans and progress reports to the HSRC and the MOHLTC no later than September 20, 1999.
Stage 2: Networked hospitals to work together to carry out the objectives and terms of reference set by the HSRC (see network tasks outlined below)
The HSRC terms of reference took into consideration the MOHLTC Rural and Northern Health Care Framework and the progress that had been achieved voluntarily by some networks.

## Network Tasks (Terms of Reference)

1. To ensure that the right organizational processes and structures are in place to develop further the network (i.e., sizing, siting, sharing, rationalizing services provision). This process is to include sizing and siting of:

### Acute Services

- *Secondary Referral Hospitals:*
  The MOHLTC and the secondary referral hospitals will work together to apply the HSRC benchmarks to these hospital(s) and determine the configuration of services, where required, through the MOHLTC operating plan process.
- *Rural Hospitals:*
  The network will apply the MOHLTC/OHA benchmarks for rural hospitals. [44]

### Non-acute Hospital Services

- The MOHLTC will work with the networks to apply the HSRC's[45] benchmarks and estimate the sizing, siting and reinvestments needed for non-acute services.

2. To explore ways to encourage greater collaboration and linkages between hospitals in the network with a focus on benefits derived from:

- Sharing administrative services
- Sharing support services
- Establishing stronger clinical linkages and service clusters. This should include but not be limited to:
  - Developing standardized approaches to assess the quality of service provided (including practice guidelines/clinical protocols)

[44] MOHLTC and the OHA. *Rural and Northern Health: Parameters and Benchmarks*, Report of the Joint Committee of the MOHLTC and the OHA. July 1998.

[45] HSRC. *Change and Transition: planning guidelines and implementation strategies for home care, long-term care, mental health, rehabilitation and sub-acute care.* April 1998.

- Progressive human resource policies developed in co-operation with professional associations, unions and volunteers, recognizing that the network's most important resource is its human capital
- Providing optimal levels of service while actively promoting efficient use of available resources.

Though the HSRC had initially intended on issuing *Notices of Intention to Issue Directions* (followed by final *Directions*) to hospitals in the rural/northern networks, the regulatory changes made by the government in April 1999 prohibited the Commission from issuing any further *directions*. The HSRC's duties were changed such that it was in a position only to provide advice to the Minister of Health (see Appendix B for further discussion of regulatory changes — Ontario Regulations 272/99 and 273/99).

As a result, the HSRC amended its process as follows:

**Figure VII-1: HSRC approach to rural/northern networks**

**Stage 1: Identify and confirm network membership.**

- To initiate formal linkage(s) between rural hospitals [within each network] and their major secondary referral hospital; and,
- To articulate what needs to be done by each of the networks as part of 'Stage 2' activities.

The Stage 1 reports were released to each of the networks in March 1999 with a request for networks to submit work plans and progress reports to the HSRC and the MOHLTC no later than September 20, 1999.

**Stage 2: Networked hospitals to work together to carry out the objectives and terms of reference set by the HSRC (see network tasks outlined below)**

The HSRC terms of reference took into consideration the MOHLTC *Rural and Northern Health Care Framework* and the progress that had been achieved voluntarily by some networks.

## Network Tasks (Terms of Reference)

1. To ensure that the right organizational processes and structures are in place to develop further the network (i.e., sizing, siting, sharing, rationalizing services provision). This process is to include sizing and siting of:

### Acute Services

- ***Secondary Referral Hospitals:***
  The MOHLTC and the secondary referral hospitals will work together to apply the HSRC benchmarks to these hospital(s) and determine the configuration of services, where required, through the MOHLTC operating plan process.
- ***Rural Hospitals:***
  The network will apply the MOHLTC/OHA benchmarks for rural hospitals. [44]

### Non-acute Hospital Services

- The MOHLTC will work with the networks to apply the HSRC's[45] benchmarks and estimate the sizing, siting and reinvestments needed for non-acute services.

2. To explore ways to encourage greater collaboration and linkages between hospitals in the network with a focus on benefits derived from:

- Sharing administrative services
- Sharing support services
- Establishing stronger clinical linkages and service clusters. This should include but not be limited to:
  - Developing standardized approaches to assess the quality of service provided (including practice guidelines/clinical protocols)

[44] MOHLTC and the OHA. *Rural and Northern Health: Parameters and Benchmarks*. Report of the Joint Committee of the MOHLTC and the OHA. July 1998.

[45] HSRC. *Change and Transition: planning guidelines and implementation strategies for home care, long-term care, mental health, rehabilitation and sub-acute care*. April 1998.

- Establishing common methods to improve utilization
- Developing common credentialling
- Providing peer review among the network's members
- Developing a common strategy (strategic plan) and creating an operational plan to serve the network's needs and assist clinical, operation and financial decisions.

3. To clarify linkages and expectations among network partners and ensure access to services at secondary referral centres.

4. To identify linkages with regional referral centres and ensures access to tertiary/quaternary services.

5. To develop strategies on common or shared human resource issues.

6. To develop recruitment and retention strategies for medical staff and other health professionals.

7. To explore mechanisms for shared or common health information systems.

8. To seek opportunities that may exist within the network to:

    - Establish multi-disciplinary group practice work teams within the hospital or other locations in the network
    - Enhance training/educational opportunities for the education of health professionals
    - Initiate telemedicine/telecommunication initiatives that support the needs of the network
    - Develop stronger partnerships with other health providers and organizations in the network to provide better care (i.e. patient-centred approach)

In September 1999, each of the networks submitted (to the HSRC and the MOHLTC) a report on their progress with the Terms of Reference. Adoption of and progress on the development of the networks varied widely among Ontario's rural and northern communities.

- Some hospitals reported exploring the merits of network formation, others had agreed to establish a network and had prepared a work plan to address targeted tasks, while a few reported the development of joint agreements and organizational structures to advance network activities.

- Most networks had articulated a mission and vision statement focused on improving access to high quality services, increasing integration and co-ordination of services across providers, and supporting innovation and creativity in improving rural health services.

- Networks proposed a variety and range of organizational structures to support the planning and decision-making required to advance and co-ordinate network activities.

- A few of the networks reported on completion of sizing and siting non-acute care services using the HSRC's planning guidelines.

The HSRC's review of all of the submissions led to the development of final advice and recommendations on rural and northern hospital networks. The advice, provided to the Minister of Health in February 2000, addressed three main areas:

1. Confirmation of network membership (see Figure VII-2).

2. Strategies and policy mechanisms to assist hospitals in the establishment of networks, particularly related to incentives and the provision of infrastructure support to expedite the formation and functions of networks,

3. Recommendations on organizational structures for each of the networks, as well as advice on the sizing and siting of acute and non-acute hospital services.

**Figure VII-2: Rural and Northern Networks**

NETWORK 1: SIMCOE/MUSKOKA
Huntsville District Memorial Hospital, HUNTSVILLE
Royal Victoria Hospital, BARRIE
Collingwood General and Marine Hospital, COLLINGWOOD
Midland District Hospital, MIDLAND
Orillia Soldiers' Memorial Hospital, ORILLIA
Penetanguishene General Hospital, PENETANGUISHENE
Penetanguishene Mental Health Centre, PENETANGUISHENE
NETWORK 2: GREY/ BRUCE
Grey Bruce Health Services, OWEN SOUND
South Bruce Grey Health Centre, KINCARDINE
Hanover and District Hospital, HANOVER
NETWORK 3: WELLINGTON
Groves Memorial, FERGUS
Louise Marshall Hospital, MOUNT FOREST
Guelph General Hospital, GUELPH
St. Joseph's Hospital and Home, GUELPH
The Homewood Health Centre, GUELPH
Palmerston and District Hospital, PALMERSTON
NETWORK 4: HALDIMAND / HAMILTON
Dunnville War Memorial, DUNNVILLE
West Haldimand General Hospital, HAGERSVILLE
Hamilton Health Sciences Corporation, HAMILTON
NETWORK 5: THAMES VALLEY
St. Thomas-Elgin General Hospital, ST. THOMAS
Strathroy Middlesex General Hospital, STRATHROY
Woodstock General Hospital, WOODSTOCK
Alexandra Hospital, INGERSOLL
Tillsonburg District Memorial Hospital, TILLSONBURG
Four Counties Health Services, NEWBURY
London Health Sciences Centre, LONDON
St. Joseph's Health Centre, LONDON
NETWORK 6: NIPISSING / TEMISKAMING
Englehart and District Hospital, ENGLEHART
Mattawa General Hospital, MATTAWA
West Nipissing General Hospital, STURGEON FALLS
Temiskaming Hospital, NEW LISKEARD
North Bay General, NORTH BAY

3. Recommendations on organizational structures for each of the networks, as well as advice on the sizing and siting of acute and non-acute hospital services.

**Figure VII-2: Rural and Northern Networks**

**NETWORK 1: SIMCOE/MUSKOKA**

South Muskoka Memorial Hospital, BRACEBRIDGE
Huntsville District Memorial Hospital, HUNTSVILLE
Royal Victoria Hospital, BARRIE
Collingwood General and Marine Hospital, COLLINGWOOD
Huronia District Hospital, MIDLAND
Orillia Soldiers' Memorial Hospital, ORILLIA
Penetanguishene General Hospital, PENETANGUISHENE
Penetanguishene Mental Health Centre, PENETANGUISHENE

**NETWORK 2: GREY/ BRUCE**

Grey Bruce Health Services, OWEN SOUND
South Bruce Grey Health Centre, KINCARDINE
Hanover and District Hospital, HANOVER

**NETWORK 3: WELLINGTON**

Groves Memorial, FERGUS
Louise Marshall Hospital, MOUNT FOREST
Guelph General Hospital, GUELPH
St. Joseph's Hospital and Home, GUELPH
The Homewood Health Centre, GUELPH
Palmerston and District Hospital, PALMERSTON

**NETWORK 4: HALDIMAND / HAMILTON**

Haldimand War Memorial, DUNNVILLE
West Haldimand General Hospital, HAGERSVILLE
Hamilton Health Sciences Corporation, HAMILTON

**NETWORK 5: THAMES VALLEY**

St. Thomas-Elgin General Hospital, ST. THOMAS
Strathroy Middlesex General Hospital, STRATHROY
Woodstock General Hospital, WOODSTOCK
Alexandra Hospital, INGERSOLL
Tillsonburg District Memorial Hospital, TILLSONBURG
Four Counties Health Services, NEWBURY
London Health Sciences Centre, LONDON
St. Joseph's Health Centre, LONDON

**NETWORK 6: NIPISSING / TEMISKAMING**

Englehart and District Hospital, ENGLEHART
Mattawa General Hospital, MATTAWA
West Nipissing General Hospital, STURGEON FALLS
Temiskaming Hospital, NEW LISKEARD
North Bay General, NORTH BAY

## NETWORK 7A: WEST OTTAWA VALLEY*

Almonte General Hospital, ALMONTE
Arnprior and District Hospital, ARNPRIOR
Carleton Place and District Hospital, CARLETON PLACE
Queensway-Carleton Hospital, NEPEAN
Kemptville and District Hospital, KEMPTVILLE

## NETWORK 7B: EAST OTTAWA VALLEY

Hawkesbury General Hospital, HAWKESBURY
Winchester and District Memorial Hospital, WINCHESTER
The Ottawa Hospital, OTTAWA

## NETWORK 8: WEST CHAMPLAIN

Deep River District Hospital, DEEP RIVER
Renfrew Victoria Hospital, RENFREW
St. Francis Memorial, BARRY'S BAY
Pembroke General, PEMBROKE

## NETWORK 9: WEST ALGOMA

North Algoma Health Organization (Lady Dunn General), WAWA
Sault Ste. Marie General Hospital, SAULT STE. MARIE
Plummer Memorial Hospital, SAULT STE. MARIE
Thessalon Hospital, THESSALON
Matthews Memorial, RICHARDS LANDING
Hornepayne Community Hospital, HORNEPAYNE

## NETWORK 10: HURON/PERTH

Alexandra Marine & General Hospital, GODERICH
Clinton Public Hospital, CLINTON
Listowel Memorial Hospital, LISTOWEL
Seaforth Community Hospital, SEAFORTH
South Huron Hospital, EXETER
Stratford General Hospital, STRATFORD
St. Mary's Memorial Hospital, ST. MARY'S
Wingham & District Hospital, WINGHAM

## NETWORK 11: SUDBURY AREA

St. Joseph's Health Centre, BLIND RIVER
Espanola General Hospital, ESPANOLA
Manitoulin Health Centre, LITTLE CURRENT
St. Joseph's General Hospital, ELLIOT LAKE
Sudbury Regional Hospital, SUDBURY
West Parry Sound Health Centre, PARRY SOUND

## NETWORK 12 & 14: NORTHWEST

Nipigon District Memorial Hospital, NIPIGON
Geraldton District Hospital, GERALDTON
Manitouwadge General Hospital, MANITOUWADGE
Wilson Memorial General Hospital, MARATHON
McCausland Hospital, TERRACE BAY
Thunder Bay Regional Hospital, THUNDER BAY
St. Joseph's Care Group, THUNDER BAY
Lake of the Woods District Hospital, KENORA
Riverside Health Care Facilities, FORT FRANCES
Dryden District General Hospital, DRYDEN
Red Lake Margaret Cochenour Memorial Hospital, RED LAKE
Sioux Lookout District Health Centre, SIOUX LOOKOUT
Sioux Lookout Zone Hospital, SIOUX LOOKOUT
Atikokan General Hospital, ATIKOKAN

* Perth and Smiths Falls District Hospital, SMITHS FALLS, originally included in this Network, is to establish a network linkage with Kingston General Hospital.

**NETWORK 13: NORTHEAST**

Anson General Hospital, IROQUOIS FALLS
Bingham Memorial Hospital, MATHESON
Chapleau Health Services, CHAPLEAU
Kirkland and District Hospital, KIRKLAND LAKE
Lady Minto Hospital, COCHRANE
Notre Dame General, HEARST
Sensenbrenner Hospital, KAPUSKASING
Smooth Rock Falls General, SMOOTH ROCK FALLS
Timmins and District Hospital, TIMMINS

**NETWORK 15: ALLISTON/NEWMARKET**

Stevenson Memorial Hospital, ALLISTON
York County Hospital, NEWMARKET

**NETWORK 16: CORNWALL AREA**

Glengarry Memorial Hospital, ALEXANDRIA
Cornwall General Hospital, CORNWALL
Hôtel Dieu Hospital, CORNWALL

**NETWORK 17: (BRANT/NORFOLK)**

Norfolk General Hospital, SIMCOE
Brantford General Hospital, BRANTFORD
Willett General Hospital, PARIS

**NETWORK 18: DUFFERIN / NORTHWEST GTA**

Dufferin-Caledon Health Care Corporation, ORANGEVILLE
Northwest GTA Hospital Corporation, BRAMPTON

The approach taken by the HSRC to address the restructuring needs of rural and northern networks was significantly different than initially anticipated. The introduction of the rural and northern framework, and the regulations amending the HSRC's powers in the spring of April 1999 modified the HRCS's course of action. In the end, the HSRC took a much more conceptual approach to hospital restructuring within the networks, rather than addressing directly the governance and operational issues related to the roles and relationships between network hospitals.

As the Commission closes its doors it is apparent that the creation of networks of rural and northern hospitals, each including at least one secondary referral hospital, remains a "work in progress". Whereas some parts of the province will be well served by functional networks, Huron-Perth counties, for example, in other areas the networks remain hypothetical at best. They do not function (and in some cases clearly do not intend to function) collectively in a co-ordinated and planned way to provide the people they serve with accessible hospital services provided at the highest possible quality in the most cost-effective way.

It remains for the MOHLTC and for the hospitals and populations in these areas, to complete the formation of effective hospital networks. Equity demands that this be done throughout Ontario. The Commission hopes that the government will proceed with full implementation of the HSRC's advice, which remains confidential to this point, regarding development of the networks within two years (i.e., by February 2002) of the date of submission of that advice.

**[illegible]: WEST OTTAWA VALLEY***

[illegible] Hospital, ALMONTE
[illegible] Hospital, ARNPRIOR
[illegible] and District Hospital, CARLETON PLACE
[illegible] Hospital, DEPEAR
[illegible] and District Hospital, KEMPTVILLE

**[illegible]: EAST OTTAWA VALLEY**

[illegible] General Hospital, RUSSELL
[illegible] and District Memorial Hospital, WINCHESTER
[illegible], OTTAWA

**[illegible]: WEST CHAMPLAIN**

[illegible] District Hospital, DEEP RIVER
[illegible] Hospital, RENFREW
[illegible] Memorial, BARRY'S BAY
[illegible] General, PEMBROKE

**[illegible]: WEST ALGOMA**

[illegible] Health Organization (Lady Dunn General),
[illegible] Algoma General Hospital, SAULT STE. MARIE
[illegible] Memorial Hospital, SAULT STE. MARIE
[illegible] Hospital, THESSALON
[illegible] Memorial, RICHARDS LANDING
[illegible] Community Hospital, HORNEPAYNE

**[illegible]: HURON/PERTH**

[illegible] & General Hospital, GODERICH
[illegible] Hospital, CLINTON
[illegible] Memorial Hospital, LISTOWEL
[illegible] Hospital, SEAFORTH
[illegible] Hospital, EXETER
[illegible] General Hospital, STRATFORD
[illegible] Memorial Hospital, ST. MARY'S
[illegible] District Hospital, WINGHAM

**[illegible]: SUDBURY AREA**

[illegible] Health Centre, BLIND RIVER
[illegible] General Hospital, ESPANOLA
[illegible] Health Centre, LITTLE CURRENT
[illegible] General Hospital, ELLIOT LAKE
[illegible] Regional Hospital, SUDBURY
[illegible] Sound Health Centre, PARRY SOUND

**[illegible]: NORTHWEST**

[illegible] General, DRYDEN
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]

Lake of the Woods District Hospital, KENORA
Riverside Health Care Facilities, FORT FRANCES
Dryden District General Hospital, DRYDEN
Red Lake Margaret Cochenour Memorial Hospital, RED LAKE
Sioux Lookout District Health Centre, SIOUX LOOKOUT
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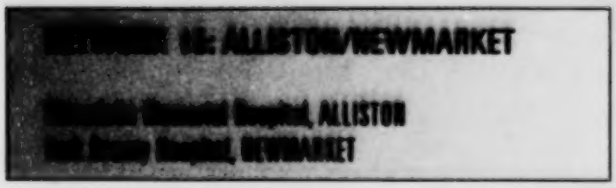


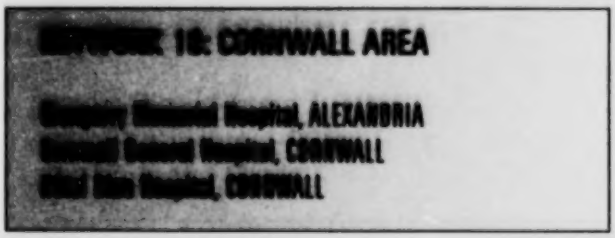

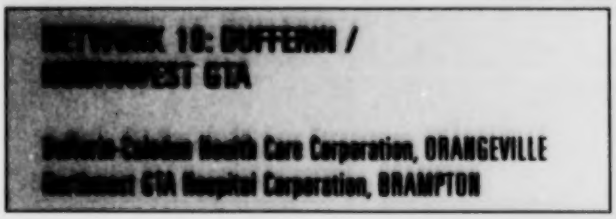


The approach taken by the HSRC to address the restructuring needs of rural and northern networks was significantly different than initially anticipated. The introduction of the rural and northern framework, and the regulations amending the HSRC's powers in the spring of April 1999 modified the HRCS's course of action. In the end, the HSRC took a much more conceptual approach to hospital restructuring within the networks, rather than addressing directly the governance and operational issues related to the roles and relationships between network hospitals.

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# Section VIII: Human Resources Planning and Labour Adjustment

HSRC Consultation

Background: Legislative Support for Restructuring the Health Sector

Labour Relations Environment

Consultation Findings

Key Lessons

Implementation

The Future: Learning from the Past

A Final Word

HSRC

# SECTION VIII: HUMAN RESOURCES PLANNING AND LABOUR ADJUSTMENT

Starting in the early 1990s, DHCs consulted and made recommendations to the Minister of Health concerning the restructuring of local hospitals in their region. An important component of many of these recommendations focused on the development, by the affected parties, of human resources plans (HR plans) embodying principles of fairness with regard to recognition of service and portability of benefits. The purpose was to effect a humane and orderly transition from the status quo.[46]

Even prior to the establishment of the HSRC, hospitals and unions in Windsor, London, and Sarnia had negotiated framework agreements for hospital labour adjustment based upon DHC reports.

In a number of communities, the HSRC appointed facilitators (labour convenors) to assist hospitals and employee groups to develop human resources plans to aid in labour adjustment. The facilitators/ convenors brought the parties together to develop "city-wide" (and in some instances "region-wide") plans for labour adjustment, as well as plans to address issues specific to a small number of hospitals and/or that the parties agreed needed to be discussed at a local level.

Toward the end of its mandate, the HSRC met with representatives of labour, management and government to discuss the processes used to develop the human resources plans, and review the key findings and lessons learned of the process. The Commission is grateful to those who participated in the interviews on labour adjustment/human resource experiences. Congratulations are due to the parties for their extraordinary accomplishment in transcending interest differences and developing comprehensive plans, which now cover most of the province.

This section of the report summarizes the results of the HSRC's consultation initiative related to the development of labour adjustment/human resources processes.

## HSRC Consultation

The Commission retained L. Victor Pathe to facilitate consultations with representatives of key labour unions, hospital management and government and to leave a record of the experience of the parties with the process.[47] Mr. Pathe had, in fact, participated in the development of human resources plans in a number of capacities: both as fact finder and convenor-mediator for Metro Toronto and as convenor/ facilitator and mediator in several other communities. He knew the players and was able to suggest, as participants to be interviewed as part of the HSRC's consultation, key persons who had been involved in human resources plan negotiations. The consultative panel[48] met with participants during September and October of 1999. For both the scheduling convenience of the participants and to encourage a frank exchange, meetings were usually held with one participant at a time. All of the major unions involved in the hospital sector were invited, and all but one agreed to attend.

Management invitees were selected to reflect the wide range of experience with human resources plan

[46] Appendix D lists fairness principles drawn from the *Essex County Win/Win Model: An Evolving Plan for Total Health System Reconfiguration*, the Final Report from the Essex County DHC Steering Committee on Reconfiguration, 1994.

[47] See Appendix D for the list of consultation respondents.

[48] The panel included L. Victor Pathe (Pathe Gardner and Associates), Suzanne Silk Klein (associate with Pathe Gardner), and Mario Tino and Beverley Nickoloff (staff of the HSRC).

negotiation from communities that were well into implementation of agreements to those where negotiations were stalled or were still under way. The OHA and relevant government ministries were consulted. Denise Wilson and Victor Pathe, both who served as facilitators for the Commission, also shared their experiences. The format of the meetings involved a short introductory statement by the participants with follow-up questions and informal discussion.

Participants were informed in advance of the kind of information the HSRC was seeking. They were encouraged to bring along knowledgeable associates and to provide a written submission. Participants spoke freely and openly. In many cases the presentations provided a chronology and were rich in detail, documenting the effect of personalities, local history, circumstances, and issues on the process.

The consultative panel probed to determine what barriers developed, why, and how they were surmounted. The panel was also interested in learning about the effect of personalities and local issues on the conduct of the negotiations. Follow-up questions about implementation were asked where appropriate.

## Background: Legislative Support for Restructuring the Health Sector

Regulations (Ont. Reg. 87/96 and 88/96) gave the HSRC the authority to issue *Directions* to hospitals, but did not confer any authority over unions, whose participation could not be compelled and could be assured ***only*** when unions considered co-operation to be in the best interest of their members. In addition, the HSRC had only the authority to advise the Minister with regard to the provincial divestiture of PPHs from provincial operation and/or on issues related to reinvestments in, for example, home care and long-term care required to support hospital restructuring.

The HSRC began its review in every community with a study of the local DHC report. Lead and associate commissioners for the community then met with key stakeholders in the community including hospital boards, representatives of the DHC and CCAC, trade union leaders, medical staff, representatives of the local Academy of Medicine and the Ontario Nursing Association, as well as municipal politicians. The HSRC also placed notices in the local papers welcoming written submissions on the local DHC recommendations and hospital restructuring in general. When it issued its *Notices of Intention to Issue Directions* (its initial report), the HSRC traveled to the community, met first with hospital board chairs and CEOs, and representatives of the local DHC before releasing the report at a press conference attended by the media. Separate briefing sessions were held for local politicians and key stakeholders in the community, including key representatives of the trade unions. Finally, the HSRC provided 30 days for comments and further submissions on the *Notices* before issuing its final *Directions* and report.

It was certain from the beginning that hospital restructuring would have enormous consequences for hospital staff: management, health professionals (including physicians), and indirect care personnel. The Commission recognized that labour adjustment was an important consideration, that collective agreements inadequately addressed the "new world" of health services restructuring, and that a rational way of dealing with change had to be developed. At the time the HSRC began its work no one could estimate how many jobs would be lost or otherwise affected. However, having the parties address the problem *locally* through planning and without Commission intrusion or prescription proved to be the best strategy. The HSRC *Directions* in each community therefore included the requirement that the parties develop a human resources plan. The Windsor, London and Sarnia

agreements made before the Commission started its work were available as models.[49]

## Labour Relations Environment

The legislated collective bargaining framework under which hospitals function, actual collective bargaining practices, and labour market realities have all had an impact on the negotiation of HR plans.

First, collective bargaining in Ontario hospitals is governed by the Hospital Labour Disputes Arbitration Act ("HLDAA") R.S.O. 1990 Ch. H. 14 as amended. The HLDAA provides for binding arbitration to resolve collective bargaining impasses and arbitration and has been resorted to with considerable frequency. In fact, some of the respondents interviewed believe that the legislation has not encouraged the parties to conclude a collective agreement by negotiation but has led to a culture of reliance upon arbitration to resolve collective bargaining interest disputes. However, in developing an HR plan parties generally have had to negotiate to agreement in a multi-partite environment and to tight timelines. Moreover, although there were models of procedure and content in human resources plans already concluded in other communities, parties have had to agree to a process and to the language of the plan from scratch. Thus, access to arbitration has been available only by agreement.

A second characteristic is that Ontario hospitals have voluntarily engaged in central collective bargaining through the OHA. However, the OHA's mandate does not extend to participating actively in human resource plan negotiations. Some respondents noted that hospital negotiators, whether CEOs or HR professionals, have had limited experience in free collective bargaining. On the other hand, some believe that the same lack of bargaining history had a corresponding advantage in the development of HR plans in that it may have enabled the parties to approach this task as a joint problem-solving enterprise rather than as an adversarial exercise.

While the HR negotiations were occurring, the Ontario Government passed Bill 136, The Public Sector Labour Relations Transition Act, SO 1997, c. 21, Schedule B, which changed the labour relations rules for hospitals being restructured. The purpose of the Act is to facilitate restructuring by providing expeditious processes for determining which union has representation rights and which collective agreement will prevail where there are program transfers and the parties can not agree. Organized labour, however, was strongly opposed to the Act at the time. The employers were uncertain about outcomes and generally tried to avoid having the unions trigger provisions of the Act.

Finally, in the course of negotiations, estimates about the labour market impact of proposed health sector restructuring shifted markedly, improving both morale and the negotiating atmosphere. At the ourset there was fear of massive lay-offs. Interviews, however, revealed there was strong motivation on both sides to mitigate negative impacts on hospital employees (or physicians). Unions wanted to provide a monetary cushion for employees and hospitals acceded to generous severance and voluntary exit options to maintain staff morale and avoid lay-offs. Hospitals were helped in this by the availability of special funds to facilitate labour adjustment (see further discussion in Section V).

Although it became clear over time that there were emerging labour shortages in certain professional areas, which alleviated earlier fears of massive lay-offs for the most part, the parties remained motivated

[49] The consultations, which form the basis of this report, did not address the situation of physicians. The HSRC dealt separately with the issue of human resources planning and movement of doctors (see Section IX of this report) by appointing a panel of fact-finders mandated to consult with physician and academic leaders in London, Ottawa and Toronto in January 1998. The HSRC issued the fact finders' report (including principles and recommendations for addressing the impact of restructuring on physicians in a systematic and fair manner) as a discussion document later that year.

to reach agreement. In most instances, the HR plans helped provide some predictability for the parties and an orderly process for managing staff transfers.

## Consultation Findings

While participants had different perspectives on a range of issues, a number of common themes emerged from the consultation. The key findings about human resources/labour adjustment that accompanied restructuring are summarized below.

### Labour relations realities:

Certain barriers and complexities could be predicted, although as the consultation revealed, they affected parties differently.

First, unions and their members considered their current collective agreements as sacrosanct and resisted processes that attempted to supersede collective agreement provisions. One union's (CUPE) reluctance to consider modifying any labour adjustment clauses, even with counter-balancing new benefits, led to the decision not to participate in negotiations. A second potential barrier concerned the overall importance of seniority issues for both unions and employers. Amalgamations, consolidations, and program transfers raised significant questions about seniority. Each union was concerned to protect the rights of its members.

- *Would seniority lists be merged? If so, how?*
- *How would non-union employees be treated and how would their service relate to the seniority of union members?*
- *How extensive would bumping rights be?*

On the other hand, hospital management wanted a smooth and expeditious transition and was concerned about maintaining quality patient care during and after implementation of the restructuring process.

A third issue related to the right of the worker to follow the work that was being relocated. Amalgamations and program transfers could result in competing rights among workers, and between unions, and involve different collective agreements and terms and conditions of employment, which had to be harmonized. Moreover, what "following the work" meant with regard to the rights of support or indirect care staff was not always clear and often very difficult to resolve.

Another major problem involved the nature and complexity of multi-partite negotiations. The structure of these negotiations differed markedly from collective bargaining in this sector. First, there was no legislated procedure and prescribed dispute resolution mechanism: parties had to develop their own process. Second, the parties were not working from a pre-existing agreement, but were required to create the agreement itself under tight timelines — a daunting task even with models of plans that had been concluded in other communities. Moreover, central bargaining in this sector meant that the OHA on behalf of the hospitals negotiated separately with each union. In this case, human resources plans were to be developed locally with all affected parties at the table, parties who, in a shifting environment of perceived shrinking possibilities, often considered themselves competitors.

Each side of the table had potential winners and losers and almost all respondents noted that conflicts within each labour group could be as severe as those between unions and employers. Finally, scheduling meetings with so many participants required skilful co-ordination. Failure to co-ordinate schedules at the outset could result in intermittent meetings and a protracted process. Adding to the difficulties in these multi-partite negotiations was the impact of non-participants as "observers" at the table.

**Barriers perceived by the parties:**

Both labour and management identified a number of issues, problems or barriers. Several participants noted that parties in general lacked a broad system-wide view — understandable given their experience and interests. ONA was an exception, perhaps because it is a one-profession union, which is generally not in competition with other unions for representation rights.

On the employer side, several interviewees noted that most hospital CEOs were preoccupied with budget constraints, with the future of their hospital, and, in some cases were concerned about their own jobs. It was also noted that in Metro Toronto the lack of a broad 'system-wide' approach was exacerbated by high turnover in CEOs over the previous few years. Therefore, Metro CEOs did not know each other as well as those in some other communities and had little history of working together. According to some interviewees, some CEOs may also have retained a private sector competitive approach. A number of participants noted that there was a clear cultural difference between teaching and non-teaching hospitals, particularly in Toronto, which made finding a common approach to labour adjustment even more difficult.

Some participants attributed the lack of a wider perspective to the absence of a true system-wide approach to planning by the Ministry (or anyone). They saw hospital restructuring as only one part of the needed health system reorganization and considered that labour adjustment planning would have been both easier and more complete had a larger, more comprehensive reform process taken place.

Respondents also described significant interest differences within each group, which made arriving at a co-ordinated position difficult. Moreover, scheduling for a large negotiating group was a continuing problem in most communities. Finally, hospitals, which were attempting to negotiate a common agreement for both the reorganization of public hospital services and the absorption of PPHs, found themselves stymied. Separation of the two exercises permitted at least some agreement regarding plans for public hospital to public hospital transfers and amalgamations.

In retrospect, respondents noted that the attendance as "observer" of one non-participating union complicated discussions and inhibited agreement. In some cases, as soon as the observer withdrew, stalled negotiations were successfully resumed. But at the start of the process the parties did not anticipate the constraining effect of the presence at the table of a non-participant.

The panel explored a number of the key issues on which labour and management disagreed. For example, process difference emerged early about dispute resolution of negotiation impasses. Some management participants alluded to past experience with arbitration under the HLDAA to explain why hospitals in some communities were reluctant to provide for arbitration, fearing that arbitration would remove accountability for an expeditious negotiated resolution and that trade-offs would become more difficult. They anticipated that unions might sign-off on advantageous provisions and refer counter-balancing, less advantageous ones to arbitration. One hospital spokesperson, however, explained that antipathy to arbitration was partly due to the recognition that "negotiated agreements are easier to interpret and implement than arbitrated ones." Unions, for the most part, wanted a neutral individual or body to resolve disputes. They were comfortable with arbitration and thought it could expedite the process.

In the final analysis, the outcome of this disagreement proved unimportant; almost all negotiations concluded without impasses that required arbitration. Rather, facilitation and mediation assisted parties in resolving issues, overcoming interest and position

differences, and arriving at agreement. Where agreement to use arbitration was included in a "Terms of Reference" document, it served to encourage voluntary settlements, a condition which contrasts with previous experience in hospital collective bargaining.

Dispute resolution during the implementation stage was also somewhat contentious. One union, in particular, insisted that a binding arbitration clause be part of the agreement. In such cases, hospitals have generally pressed for provisions that restrict the authority of the arbitrator.

Another touchy issue arose out of an HSRC recommendation that hospitals consider outsourcing some functions. While many Ontario hospitals had been eager to rationalize their operations in this manner, unions, have generally been opposed to contracting out and have been reluctant to weaken existing collective agreement language or to sanction a practice that they see as placing their members at a disadvantage and weakening their union.

The parties found it difficult to reach agreement on bumping rights. Hospitals wanted to avoid chain bumping to expedite the integration and adjustment period; unions wanted to preserve existing collective agreement rights. Agreement was often reached by a trade-off between limited bumping rights and enriched voluntary exit and severance provisions.

With regard to voluntary exit, unions often wanted broad rights to maximize choices for their members by giving all those in a classification the right to leave. Hospitals, on the other hand, preferred to limit voluntary exit to circumstances of real redundancy. Nurses were particularly concerned. Although many of them may have wanted to follow patients who were moving into community care, hospitals (who were starting to face a nursing shortage) were reluctant to let nurses go. They preferred to provide for retraining to meet changing needs, rather than pay for both voluntary exit and recruitment. As a rule, hospitals considered it to be a sound management practice to minimize adjustment costs and to assure staff continuity and availability.

**Actions and conditions that helped:**

Implementing the HSRC's *Directions* required that a plan be put in place, but according to respondents, what really brought the parties to the table was the prospect of mutual gains. Unions needed to show their members (who were apprehensive about the effects of restructuring) that their concerns were being addressed and their interests pursued. Unions also had the possibility of negotiating benefits supplementary to existing collective agreement provisions to deal with an extraordinary adjustment circumstance. On the other hand, employers needed provisions that would minimize disruption, resistance to change, or jurisdictional disputes. Both sides needed predictability.

Once negotiations began, pragmatism and flexibility helped. For example, not waiting for agreement of all unions permitted negotiators to achieve a human resources plan with at least some unions. Specifically addressing issues of concern to particular unions and a willingness to revisit agreements for modest changes resulted in subsequent additional sign-ons. In at least one case, management flexibility by providing choice between two exit provisions brought some unions into an agreement.

Some co-ordination of position was achieved by two different mechanisms. In one community, the hospital CEOs and senior HR managers met to establish common principles and present a united front. They were able to do so partly because they had earlier worked through a limited realignment of services and amalgamation. In several cases, parties appointed spokespersons to negotiate on the basis of caucus positions, which reduced the numbers at the table and made negotiations more productive.

Where the parties established a "Terms of Reference" document as well as a commitment to and definition of fairness, parties had a framework for the discussions and a basis upon which to develop and judge proposals. It was especially important where staff reduction was a serious possibility. For example, establishing a mechanism of "proportionality" regarding the assignment of indirect care staff and a measure to determine the proper numerator and denominator for calculating the ratio provided a neutral test for fairness that assured the parties.

Finally, the panel heard descriptions of how timely intervention of mediation saved foundering negotiations.

### Local circumstances and issues:

As was predicted, purely local circumstances were extremely important. For example, the choice of effective spokespersons was crucial. Here both experience and personality made the difference. Pragmatism, directness, flexibility, and credibility were as important as persuasiveness. In one case, a CEO spokesperson was able to persuade other CEOs (who were not at the table) of the necessity of compromise. It might have been more difficult for a Director of HR to speak as frankly to CEOs.

In some communities prior unresolved local issues were reflected in current difficulties. Conversely, participants from communities where there had been previous co-operation and realignment agreements all noted that past success made the current negotiations easier. In Ottawa, agreement was made possible by the postponement of one thorny local issue — bilingualism. It was recognized, however, that the issue would need to be addressed in more local cluster bargaining.

### Parties' view of the role of the HSRC:

Several respondents said they expected a more intrusive Commission that would recommend (if not prescribe) procedures, a list of HR plan contents, and minimum standards. Some described a Commission that could coerce the opposite party. Many were disappointed in the absence of effective penalties for missed deadlines or dilatory negotiations. One respondent suggested that the *Directions* should have provided for arbitration when a deadline was missed. A number of participants would have preferred a Commission role that could best be described as a "secretariat with teeth" that provided general support, co-ordinated meetings, and enforced attendance.

Some parties complained of lack of clarity or of language in the *Directions* that increased the proclivity of some employers to consider themselves the beneficiaries of a provincially arranged take-over of programs, services, or entire facilities.

In general, however, once they were reminded of the HSRC's mandate, most participants expressed satisfaction with the assistance they received from the Commission, especially in those cases where the Commission had appointed a convenor/mediator to help communities get through "difficult" periods in the negotiation process. One participant did report unhappiness over what it considered a lack of response from the Commission.

All participants noted the importance of the requirement for HR planning in the HSRC's *Directions*. Many saw it as the catalyst for bringing both parties to the table. One participant noted that once the *Directions* were issued with stated deadlines, there was great pressure on the parties to develop a plan, for fear that programs might be moved before the plan was in place. Another suggested that some parties experienced increased motivation to reach an agreement before the expiration of the Commission's mandate.

## Implementation:

Although the process of implementing HSRC *Directions* was just beginning in a number of communities at the time of the HSRC's consultations, respondents reported that generous voluntary exit options, an increasing shortage of professional staff, and careful planning had resulted in no lay-offs of persons covered by these HR plans.

However, several noted that this might change once the divestiture of the PPHs has been completed. In addition, it was noted that there had been some lay-offs where plans had not been concluded by the time of the program transfer.

A number of participants reported on the work of monitoring committees, which were provided for in all HR plans. In general, the conditions that facilitated negotiation of the plan have been reflected in the monitoring phase. Planning, fortuitous choice of committee members and co-chairs, and regular communication between parties have all been important in successful cases. The panel was impressed by an extensive description of the operation of one committee. Critical success factors that contributed to a favorable outcome in this community included: establishing regular meeting dates; confirming agendas in advance; not discussing items which were not on the agenda to avoid surprise and incomplete information; and, distributing regular progress reports. Most important, the union-management co-chairs communicated regularly and were often able to intervene to prevent a problem, rather than having to act to resolve it. As one respondent noted, "the safety valve function of a monitoring committee is extremely important."

One respondent noted that a news blackout during critical phases of negotiations was helpful, although it is also clear that regular communication with affected employees actually minimized uncertainty and made the adjustment process less disruptive.

## Divestment of Provincial Psychiatric Hospitals (PPHs):

There was general unhappiness with the process of PPH divestiture. Participants faulted insufficient prior consultation and almost all criticized the divestiture model that was proposed in most communities[50], which passed governance to a specific public hospital to be followed over time by the dispersal of beds (referred to as "decanting") among several hospitals, some quite distant from the named governing hospital. This two-stage process was cited as a key barrier that extended both the adjustment period and the attendant staff uncertainty. The Ontario Public Service Employees Union (OPSEU), representing most PPH employees, expressed concern that the HSRC mandate would expire before negotiations and implementation were completed (a concern that has now been realized), leaving a vacuum in cases that may require further advice from the HSRC (and/or *Direction* from the Minister).

The primary receiving hospitals had a number of complaints and concerns. First, integrating PPH staff into public hospitals would be difficult because many jobs existed in the former for which there were no counterparts in the latter. Thus, while there was general agreement that the worker should follow the work, there is no work to follow for some psychiatric hospital staff. Moreover, public hospitals have already downsized, but the psychiatric hospitals have not. Further downsizing would have to occur after amalgamation but before decanting. In general, staff of PPHs had greater seniority than staff in receiving hospitals and could therefore displace existing staff in any transfer of programs/services during the transitional period. Severance costs could be considerable and staff morale would suffer. Public hospital unions

[50] These communities included: Brockville, Hamilton, Kingston, London, St. Thomas, and Thunder Bay.

expressed fear of the effects on their members. In addition, collective agreements in public hospitals differed substantially from the OPSEU agreement (which applied to the PPHs) making harmonization difficult. Participants from public hospitals expressed their belief that an OPSEU-type agreement, intended to cover the entire public service, was inappropriate to their hospital setting.

Participants noted that negotiations were complicated by the presence at the table of the Ontario Management Board of Cabinet (MBC).[51] Management Board saw its role as the employer but to the public hospitals and their unions, MBC appeared also to be a representative of the government, which funds hospitals and makes the rules under which the hospitals and their unions function. Some hospitals felt this created a power imbalance in the discussions, which made statements by the MBC representative appear more like orders than a negotiating position, regardless of the intention of the representative. Several consultation participants said they felt that MBC represented the Treasury as much as it did the PPHs.

At the time of the HSRC's consultation, the parties had not solved their problems with respect to the divestiture of PPHs although centralized negotiations between MBC and the receiving hospitals had led some parties to believe that agreement would occur before too long. Finally, a number of participants noted the success of the divestiture of Toronto's Queen Street Mental Health facility, most probably because a new entity was created and there was no attempt to integrate the merged facilities into an existing public hospital.

## Key Lessons

Although union, management and government participants had different perspectives, a number of common themes emerged from the consultation.

To begin with, there was a high degree of agreement about which barriers inhibited progress, which actions facilitated negotiation and which impeded them, and what the parties wanted from the HSRC. With regard to the last point, the consultation itself helped parties reevaluate their experience. For example, in some instances where parties recommended greater Commission power or intervention, probing the potential impact of such an enhanced role disclosed to them disadvantages previously not considered. Participants then recognized that the Commission probably struck the right balance between prescription and no guidance at all.

### The Role of the Commission

- **Directions:** Without the *Directions* from the HSRC, restructuring either would not have happened or would have occurred more slowly and in a less organized fashion, and might have required direct government intervention.

- **HR Plans:** All parties agreed that requiring HR plans on labour adjustment issues and procedures were important.

- **Deadlines:** HSRC deadlines provided an incentive to continue negotiating; however, once those deadlines passed without penalty, pressure was removed for some parties.

[51] MBC is mandated under the Management Board of Cabinet Act and the Treasury Board Act to provide central leadership on the management of government's financial, human and physician resources in support of the government's fiscal and policy priorities and operational objectives. MBC also acts on behalf of the government as employer on issues between the government and its public sector employees and their bargaining agents, including collective bargaining.

- **HSRC Mandate:** Parties did not understand the mandate limitations of the HSRC. Parties expected, for example, more detailed direction regarding the process and content of HR plans. Other parties expected that the HSRC's involvement would extend to setting negotiation dates and ensuring attendance. More explanation of the HSRC's role and greater consultation with the parties would have been helpful. On the other hand, there is agreement that a greatly enhanced mandate and powers in this area *might* have worked adversely by alienating labour groups.

- **Meaning of HSRC *Directions:*** Some hospitals interpreted program and governance transfer to be a "take-over" which resulted in the proposal of labour policies detrimental to those transferred and made plan negotiations more difficult. It was suggested that *Directions* should have avoided language that could be interpreted in a "winner" versus "loser" manner.

- **Starting the Process:** In complex or difficult negotiations the appointment of a convenor or facilitator was crucial in starting and maintaining negotiations.

### The Role of the Parties and the Conduct of Negotiations

- **Interests:** Negotiations were difficult because of interest conflicts both within each labour/management group and across the table. Past collective bargaining experience either alleviated or exacerbated such conflicts. It was important for parties to build trust and focus on joint problem solving.

- **Creating the Process:** It proved important to agree at the outset upon Terms of Reference, ground rules and, for most parties, a dispute resolution mechanism. Enunciation of principles to ensure fairness was important.

- **Spokespersons:** Naming a credible spokesperson for each labour/management group reduced the confusion of multi-partite negotiations.

- **Setting Dates:** Co-ordination of timetables and ensuring attendance of participants was a major problem in some communities. Setting aside blocks of days for meetings at the outset was a productive strategy.

- **Observers:** Non-participant observers impeded negotiations (i.e., critical parties that sought to sit outside the process but attend the meetings in an "observer" status inhibited progress and made the facilitators' role difficult). Parties should have insisted on the commitment to the task of concluding an agreement of all those at the table.

- **Authority to Bind:** Negotiators should have the authority to conclude an agreement.

- **Models:** Earlier voluntary plans (developed in Windsor and London, for example) were helpful to the parties in providing examples of Terms of Reference, plan format and content as well as process models. Participation at some tables of those who had negotiated these plans was especially helpful.

## Implementation

- **Monitoring:** Creation of a monitoring committee with key persons as co-chairs and regular meeting dates reduced interpretation and implementation problems. Successful monitoring committees were marked not only by a commitment to planned meeting dates but also by activity between meetings and regular contact between the co-chairs.

- **Dispute Resolution:** As implementation proceeds, disputes over the interpretation of application of HR plans may require rights arbitration.

**PPHs**[52]

- **Models:** The process would have benefited from more discussion and consultation with public hospitals before the HSRC made recommendations about PPH divestment/program transfers. This might have led to a different and less problematic model. The labour relations implications of the divestiture should have been discussed and considered more fully before the divestiture model was developed.

- **Participants:** The presence at the table of the MBC as PPH employer introduced bargaining inequalities and additional interest conflicts, given that the government is both funder and rule maker.

## The Future: Learning From the Past

Parties who have not yet completed HR plans might consider some of the findings about what has contributed to successful negotiations. Parties who are setting up monitoring committees should consider the factors that characterize well-functioning committees. In addition, it is clear that future plan negotiations would benefit from formal research on the outcomes following their implementation to determine the effectiveness of the HR plans. The types of research questions identified as important to be addressed that would help inform future work in this area were as follows:

- **Status Report:** What are (were) the actual numbers of those affected by restructuring? (e.g., How many employees moved? How many took voluntary exit opportunities (VEO) or early retirement? How many were laid off? How many changed careers?)

- **Retraining:** How much and what type of retraining occurred to assist transfer, retrain existing staff, or help redundant workers find new work?

- **Issues:** What are (were) the key implementation issues, challenges and barriers faced? Did the development of HR plans facilitate restructuring, and were the monitoring mechanisms set up in the plans effective?

- **Best Practices:** What can be learned from documenting actual case studies of effective processes? Were there particular kinds of communication or counseling initiatives that alleviated stress of affected employees during restructuring?

- **Overall effect of changes:** How did staffing ratios change? What was the impact of restructuring on staff morale, patient/client satisfaction, and 'bottom-line' costs?

- **Labour adjustment in GTA/Metro Toronto:** To what extent have staff transfers occurred throughout the entire region? What has been the effect on the larger labour market?

## A Final Word

A number of parties still in negotiation expressed concerns about how the process could be sustained, and commitment to justice and equity maintained once the HSRC's mandate expired. As noted above, there is a general feeling that the HSRC provided valuable on-going services to parties in negotiation (services involving both clarification of *Directions* and provision of facilitators/mediators). In particular, a number of respondents noted that the low-profile monitoring function performed by the HSRC, and the establishment of deadlines and requirement for reports helped greatly to facilitate the development of HR plans. As a result, many respondents noted that the HSRC's departure would leave a gap. The questions asked were: ***Should that gap be filled? And, if so, how?***

[52] These issues are discussed more fully in Section VI of this report.

Three possible approaches were suggested:

1. **Self-management:** Leave it entirely to the parties. Drawing upon the experience of others, they should be expected to self-manage the negotiation process and to monitor implementation of the agreements they have achieved. However, given the intra-party conflicts noted by consultation participants, it is unlikely that deadlocked negotiations could restart without external pressure and assistance.

2. **Government function:** Locate monitoring within a Ministry. Either the Ministry of Labour or the MOHLTC could, for example, create an office to monitor negotiation of the plans and their implementation and provide assistance to the parties. An alternative could be locating the watchdog office within the Ministry of Labour. The former has responsibility for funding health services; the latter has a mandate for helping parties resolve labour disputes through mediation or adjudication. To date, neither Ministry has wanted active involvement in this particular labour adjustment process. A full-time office is probably more than is required and could persist beyond the need, but adding the function to an existing office may lead to less attention or slower response than required. More important, it contradicts the arms-length approach the government adopted in setting up the HSRC.

3. **External assistance, as needed:** Retain an outside troubleshooter, to whom the parties could appeal for mediation and other assistance. This arms-length approach is likely to inspire greater confidence of the parties, could result in speedier response and be cost-effective, since it would be activated only by request of the parties and with the approval of the funding Ministry on an as required basis.

Based on this consultation and other communication with the parties, the HSRC believes parties still in negotiation have sufficient models to assist them in creating the HR plans they need. However, the Commission cautions the parties not to let problems in reaching agreement fester unresolved and recommends that the parties seek help when needed.

# Section IX:
# Province-Wide Initiatives

## Physician Human Resource Adjustment
## Children's Services
## The Women's Health Council of Ontario
## Cancer Services
## Cardiac Services

HSRC

# SECTION IX: PROVINCE-WIDE INITIATIVES

As the HSRC proceeded with its review of Ontario's hospitals, a number of issues arose that required additional investigation and different approaches than those applied to hospital restructuring, community by community. Most of these issues were provincial in scope. The key projects/initiatives included the following:

- The appointment of a *medical human resources fact-finding team* to recommend a process to address physician human resource adjustment issues arising from health services restructuring.

- *Children's health services*, including the establishment of a Provincial Pediatric Task Force (PPTF) to assess the potential for program consolidation and co-ordination of service delivery for low volume, highly specialized tertiary and quaternary pediatric cases, such as specialized surgery and transplantation.

- Proposed establishment of a provincial *Women's Health Council.*

- Availability of *cancer services* in certain regions.

- Availability of *cardiac services* in certain regions.

The HSRC's work and deliberations in each of these areas is summarized briefly below.

## Physician Human Resource Adjustment

On August 25, 1997 the HSRC announced it was commencing fact finding on physician human resource adjustment issues arising from health services restructuring.[53] This initiative was undertaken in recognition of the scope and complexity of the medical human resources adjustments to take place in large academic health centres such as London, Toronto and Ottawa.

The process for this review was designed to involve key stakeholders in identifying the issues affecting the medical community and recommending possible options and processes to resolve them in a fair and equitable manner.

The fact finders accepted written submissions and sought direct consultation with representatives of local hospitals, physicians, universities, the OMA, the OHA and medical practitioner groups. From these consultations, the *Medical Human Resources Fact Finders Report to the Health Services Restructuring Commission*[54] was written. This Report identified the following guiding principles for its recommendations:

- Primacy of quality patient care
- Minimization of the impact of hospital restructuring on service delivery
- An open and fair process for the appointment of medical staff
- Development and use of criteria for appointment, reappointment, resource allocation and evaluation
- Support for an enhanced role for general/family practitioners

[53] The HSRC named Dr. John Atkinson (J. Atkinson Health Care Professionals, Ottawa) as Chair of a three-member task force. Also appointed were Kingston-based family physician Dr. Ruth Wilson and Dr. John F. Jarrell, Chief Medical Officer of the Calgary Regional Health Authority.

[54] *Medical Human Resources Fact Finders Report to the Health Services Restructuring Commission*. January 1998. This report was prepared by the fact finders and released by the HSRC as a discussion document.

- Maintenance of appointments for physicians affected by restructuring
- Recognition of the role of non-academic physicians in providing services
- Recognition of the essential roles of academic physicians
- Recognition of the role of teaching hospitals for quality care and academic responsibilities (education and research)
- Recognition of the need for collaborative and collegial relationships between community and academic physicians.

The report was released for review and comment in January 1998. Twenty-four written responses were received. Overall, the submissions expressed "strong support" for the principles and recommendations outlined in the report. The HSRC considered both the recommendations of the report and the written responses submitted to it. Taking these into account, the HSRC issued a series of *Notices of Intention to Issue Directions* in Toronto and the GTA/905, London, and Ottawa regions and also a number of recommendations to the MOHLTC in the form of advice to the Minister.

The HSRC did not establish a mechanism to track the impact of hospital restructuring on physicians. However, anecdotal information and correspondence received by the HSRC indicated that the principles and generic process proposed by the fact finders were useful in two particular ways:

1. Recognition of the need for a "principle based" proces[illegible] to ensure whatever adjustments were required took place in a fair and equitable manner that protected high quality patient care.
2. Identifying those institutions, including their respective governance and management structures, that fundamentally believed in the importance of implementing a "principle based" process.

There were, however, allegations expressed to the HSRC by some physicians about institutions that did not behave "fairly and equitably". These concerns were expressed primarily about the "actions and behaviors" of a small number of hospitals receiving programs and services from relinquishing hospitals (see Section IV, discussion on governance for a definition of receiving/relinquishing hospitals).

## Children's Services

Children in Ontario benefit from an extensive range of pediatric[55] services, education and research provided by, among others, highly regarded academic health science centres (AHSCs), including the Children's Hospital of Eastern Ontario (CHEO) in Ottawa, the Children's Hospital of Western Ontario [part of London Health Sciences Centre (LHSC)], the Hamilton Health Sciences Corporation (HHSC), the Hospital for Sick Children (HSC) in Toronto and the Kingston hospitals (Kingston General Hospital (KGH), and Hotel Dieu Hospital). Sault Ste. Marie, Sudbury, Thunder Bay and Windsor also offer and deliver care to children.

As part of its review of hospital services in Ontario, the HSRC identified the fragmentation of child and adolescent services as a significant health care problem requiring improved co-ordination.[56]

The happy facts, however, are that the number of sick children and the severity of their illnesses have diminished greatly throughout the province.

[55] On the basis of advice received in written submissions and the informal admission policies of many adult in-patient providers, the HSRC defined pediatrics as being limited to patients up to and including 14 years of age for all but mental health services. For child and adolescent mental health services, the HSRC developed bed targets for the population under age 18.

[56] HSRC. *Thunder Bay Health Services Restructuring Report* (October, 1996), *London Health Services Restructuring Report* (February, 1997), *Metropolitan Toronto Health Services Restructuring Report* (July, 1997), *Ottawa Health Services Restructuring Report* (August, 1997).

The result is, of course, that safeguarding the quality of care requires that pediatric services, particularly those highly specialized services described as tertiary and quaternary, be concentrated in fewer hospitals where specialized expertise, equipment and facilities can be aggregated. At present, fragmentation of such services occurs in a number of areas both within and between hospitals and among community agencies. The lack of co-ordination of pediatric services was identified as a probable source of unnecessary duplication, resource waste and less-than-optimum child health outcomes. As a result, the HSRC recommended the creation of regional pediatric networks in London, Ottawa and Toronto as a co-ordinating mechanism.

For example, in the *Metropolitan Toronto Health Services Restructuring Report* (July 1997), the HSRC confirmed its support for a new Child Health Network led by the Hospital for Sick Children including representatives from the Toronto hospitals that provide neonatal and child services. (The network initially included the Toronto hospitals, and was then broadened to include other GTA/905 hospitals). A key goal is to develop stronger linkages among the partners for patient information to facilitate timely access to information, and eliminate duplication and delays in transferring both information and patients between institutions.

In March 1997, as part of its interim report dealing with the restructuring of health services in Metropolitan Toronto, the HSRC also announced its intention to establish a Provincial Pediatric Task Force (PPTF).

The mandate of the PPTF was to assess the potential for program consolidation and co-ordination of service delivery for low volume, highly specialized tertiary and quaternary pediatric cases such as specialized surgery and transplantation[57]. Dr. J. Richard Hamilton (Montreal, Quebec) was appointed as Chair of the PPTF.[58] The PPTF submitted its report to the HSRC in December 1997.[59] Following receipt of the report, the HSRC undertook additional analyses to further address the issue of how best to make 'trade-offs' between accessibility to particularly specialized pediatric services and the high quality/low risk that derives from critical/optimal mass.

The HSRC believed that while access to care close to home is an important consideration in siting all services, it was, however, particularly relevant when considering location of tertiary and quaternary pediatric services to which not only the patient, but the child's family, often must travel. However, in making the 'trade-off' relating to the siting of such highly specialized programs (such as pediatric cardiac surgery), the HSRC holds that providing access to the highest quality of care outweighs the need for local access. Research makes it clear that quality of outcomes (whether for children or adults) is directly related to the number of similar cases handled. Moreover, critical mass facilitates the recruitment and retention of specialized staff, the enhancement of skills in performing specialized procedures and the development of effective peer review practices.

[57] The HSRC's main objective for wanting to recommend changes to the way specialized pediatric services were provided in the province was to sustain and improve the quality of care by increasing the critical mass of these programs, primarily though the consolidation of existing 'small volume' programs. It was also acknowledged, however, that another factor in maintaining quality of patient care and ensuring equitable access for children who require highly specialized services would be through increased collaboration among pediatric in-patient providers.

[58] A Professor of Pediatrics at McGill University, Dr. Hamilton is the former Chair of the Department of Pediatrics at McGill University and Physician-in-chief at The Montreal Children's Hospital.

[59] The HSRC established the task force to address program consolidation and co-ordination of service delivery related to low volume tertiary and quaternary pediatric cases. The decision to establish the task force was precipitated by the HSRC's review of health services in major centres across the province, including Thunder Bay, Sudbury, Ottawa, London, and Metro Toronto.

Given the complexity of the issue, the HSRC's review process for highly specialized pediatric services took over 18 months to complete. As its starting point, the HSRC used the recommendations provided by two expert review panels: the Provincial Pediatric Task Force and the subsequent Review Panel.[60]

The HSRC's final report which remains confidential to this point, including recommendations and advice to the Minister was submitted in February 1999.[61]

## The Women's Health Council of Ontario

In its final *Metropolitan Toronto Restructuring Report* (July 1997), the HSRC recommended to the Minister of Health that the province establish a Women's Health Council of Ontario. It was proposed that the Council be established as a separate and distinct corporate entity. The Council would advance leadership in women's health and improve the health status of women through health education and identifying and promoting best practices in women's health and health care. It was further recommended that the Women's Health Council of Ontario be guided by the following terms of reference. The Council will:

- Review world literature and national experience to identify and promote best practices in the delivery of women's health services;
- Foster demonstration projects designed to test the feasibility of introducing promising practices and other innovations in women's health care;
- Sponsor and co-fund major projects in applied research and health education to improve women's health;
- Work with existing and emerging women's health research groups and agencies to support their fund-raising activities;
- Work with women's health researchers to communicate the results of research to providers and decision-makers in the health system;
- Work with AHSCs to enhance awareness of women's health issues; and
- Ensure that Ontario is represented in national and international initiatives directed to improving women's health.

On December 8, 1998, the Minister of Health (Elizabeth Witmer) and Minister Responsible for Women's Issues (Dianne Cunningham) confirmed the establishment of the Women's Health Council and appointed Ms. Jane Pepino as Chair. The Council's official mandate is *to advise the Minister of Health on matters relating to women's health, and to ensure that the health care system is responsive to the needs of women.* The Council is working to create proactive partnerships with government, educators, business, researchers, health care organizations and other community groups in carrying out its mandate.

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[60] The HSRC concluded that the mandate assigned to the PPTF had not been fully addressed. Specifically, the lack of conclusions about the need for appropriate critical mass and greater provincial co-ordination of highly specialized, low volume pediatric services could result in a lack of access to the best quality care for these services and potentially less-than-optimum child health outcomes. Accordingly, the HSRC assembled an independent review panel comprised of three physicians from outside Ontario and asked it to review the recommendations provided by the PPTF. The Review Panel was asked to address the following questions: *Were the assumptions used by the PPTF in reaching their decisions reasonable? Were the assessment and conclusions reached by the PPTF in their review of tertiary and quaternary pediatric programs reasonable and consistent?*

[61] HSRC. *Co-ordinating And Consolidating Specialized Pediatric Services In Ontario: A Confidential Report to the Minister of Health from The Health Services Restructuring Commission.* February 1999.

## Cancer Services

Radiation and other specialized cancer services are provided on a regional basis in Ontario. Regionalization of services provides the critical mass of expertise and of patients necessary to ensure quality and maximizes use of expensive capital equipment. Since radiation treatments are usually received daily over several weeks, patients who reside outside the communities where regional centres are located must either travel daily or find accommodation away from home for periods of time.

Ontario has one provincial cancer centre – Princess Margaret Hospital of the University Health Network – and eight regional cancer centres located in Windsor, London, Hamilton, Toronto, Kingston, Ottawa (two sites), Thunder Bay and Sudbury. All are full-service centres providing radiation and chemotherapy, and all are involved in research. In addition to these centres, many other hospitals across the province provide cancer chemotherapy and surgery.

At the time the HSRC began its work, there had already been considerable investment made in radiation therapy machines in Ontario (i.e., the number of radiation machines increased from 33 in 1989-90 to 67 in 1996-97).

The HSRC assessed recent reports including the Cancer Care Ontario (CCO) document[62] when considering the need for cancer services, particularly in the GTA/905.[63] For example, CCO had recommended that to meet increased demand to 2005, available capacity be maximized through increased operating hours at existing centres in Toronto, and establishing community cancer centres in Peel and Durham without radiation treatment facilities. Key factors considered by the HSRC included future demand, accessibility and affordability.

Accessibility to cancer services is unlike most other services. Although treatment schedules are difficult for all patients, this is especially true for patients undergoing radiation cancer therapy. Often they must travel daily at considerable distances to regional centres for treatment over extended periods of time. The nature of radiation treatment is such that providing this service closer to home is a real advantage for patients over enhancing the hours of operation at existing centres far away. The HSRC also recognized that optimal mass, and affordability (related to capital and operating costs), were important factors to consider and must be balanced with issues of future demand and service accessibility.

The HSRC recommended the following:

- That additional cancer centres operated by CCO be planned for Durham and Peel as full service centres with the capacity to provide radiation services.

- That the Durham regional cancer centre be located at the Oshawa site of the Lakeridge Health Corporation and the Peel centre be located at the Credit Valley Hospital with each site having the capacity for three radiation therapy machines.

[62] *Linear Accelerator and Cobalt Unit Requirements and Hours of Operation Recommendations for Ontario 1998 to 2006.* Cancer Care Ontario, February 1998.

[63] A number of recent studies completed prior to the establishment of the HSRC, addressed the level of cancer services available in Ontario. In October 1994, the Ontario Government announced new radiation facilities to be sited at Oshawa General Hospital in Durham (later renamed the Lakeridge Hospital Corporation), and at the Credit Valley Hospital in Peel. Soon after, the then Ontario Cancer Treatment and Research Foundation (OCRTF), and representatives of the District Health Councils (DHCs) and the hospitals submitted functional plans for the Durham and Peel cancer centres. In February 1998, Cancer Care Ontario (CCO) released its report on the requirements for radiation facilities in the province over the next ten years. CCO identified expected referral patterns to potential radiation centres.

- That the Minister of Health expedite planning for these centres so that construction can begin as soon as possible with a target date of 2001 for their full operation.

- That a regional cancer treatment facility be sited in Waterloo Region at the Grand River Hospital and include the construction of three bunkers to accommodate the anticipated future workload demand in the Waterloo Region.[64] It was further recommended that the CCO and the Grand River Hospital identify local needs for cancer services, determine priorities for activities to improve and enhance cancer services and avoid duplication of these services.

- That a functional program for the upgrade and expansion of the Hamilton Regional Cancer Centre be developed by the Hamilton Health Sciences Centre in collaboration with Cancer Care Ontario.

- That a three bunker cancer centre be built in St. Catharines (at the St. Catharine's General site) to serve the Niagara region.

## Cardiac Services

Specialized cardiac services include diagnostic catheterizations (angiography), invasive catheterizations (angioplasty or percutaneous transluminal coronary angioplasty – PCTA), stenting and cardiac surgery (including bypass grafting and valve surgery).

There are currently eight full service cardiac centres in the province located in Toronto (3), Hamilton, Ottawa, London, Kingston and Sudbury. There are an additional four centres with services limited to diagnostic cardiac catheterizations located in Toronto, Windsor, Thunder Bay and Sault Ste. Marie.

The planning of specialized cardiac services must be undertaken within a broad context guided by provincial targets and standards. The Cardiac Care Network of Ontario (CCN) is an advisory body to the MOHLTC mandated to advise on a province-wide cardiac care system, monitor waiting patterns for surgery services and develop guidelines and standards for access and delivery of services.

Expanding cardiac services was an issue raised in the review of the GTA/905, Windsor/Essex, Haliburton, Kawartha, Peterborough and Renfrew Counties, Waterloo and other communities.

In the Fall of 1997, the Cardiac Care Network of Ontario (CCN) convened an expert panel to develop a consensus on guidelines for providing cardiac surgical services in Ontario. At about that time, CCN released its report, *Consensus Panel on Cardiac Surgery Services in Ontario: Final Report and Recommendations.* [65] The report was preceded by another CCN report on guidelines for cardiac catheterization services.[66]

A number of the findings in the two CCN reports were relevant to cardiac services delivery in the GTA/905. These included the following:

[64] In the case of the Durham regional cancer centre (to be located at the Lakeridge Health Corp.) and the Peel Centre (to be located at the Credit Valley Hospital) and the Waterloo centre, it was anticipated that the host hospital would offer a variety of services to complement the activities of the regional cancer facility. These might include diagnostic services such as imaging; clinical support services such as laboratory; and, administrative and support services such as finance, health records, materials management.

[65] Cardiac Care Network of Ontario. *Consensus Panel on Cardiac Surgery Services in Ontario: Final Report and Recommendations.* April 1998.

[66] Cardiac Care Network of Ontario. *Consensus Panel on Cardiac Catheterization Laboratory Services in Ontario: Final Report and Recommendations.* September 1997.

- Sufficient cardiac services should be considered in each MOHLTC planning region to meet the projected needs of residents, provided that minimum volumes to ensure quality and efficiency can be maintained.
- A minimum of 500 diagnostic catheterizations and 400 PTCA[67] procedures should be completed at each cath lab site per year to ensure quality outcomes.
- A minimum of 500 cardiac surgical cases (requiring the use of pump or pump stand-by) should be completed at each cardiac surgical centre to ensure quality outcomes.
- New cardiac centres should provide both diagnostic and interventional cardiac services, including cardiac surgery.
- Capacity at current cardiac centres should be maximized prior to establishing any new cardiac centres.
- Consideration should be given to establishing new cardiac centres that would provide cath lab and cardiac surgical services in the Central East region.

There was considerable pressure on the HSRC from local communities to consider recommending additional cardiac services in the Central and Southwestern regions of the province. The HSRC undertook an in-depth review of the number of additional surgical procedures that would be required by the year 2003 (based on population growth and a target of 100 procedures/100,000 population). The HSRC also considered a number of alternatives that would allow these procedures to be completed in a manner consistent with the objectives of quality, accessibility and affordability.

The HSRC's decisions were influenced by the results of a capacity survey undertaken by CCN and detailed in its April 1998 report on cardiac surgery services. Consistent with CCN's recommendation that catheterization not be done in hospitals without the capacity for open-heart surgery, the HSRC considered only options that sited the full range of cardiac services, including diagnostic catheterization, PTCA and cardiac surgery for reasons pertaining to both quality and safety.[68]

The HSRC's final recommendations on cardiac services in the Central and Southwestern region of the province included the following:

- The decision on where to site new services must take into account current as well as long-term needs.
- Expanding services in current centres in the Toronto region would not establish a firm foundation on which to meet future needs of GTA/905 residents. However, HSRC noted that the current sites operate at levels that meet quality and efficiency standards. Siting new services elsewhere would not compromise the volume of cases needed by these centres to maintain these standards.
- Peel region (GTA/905) was identified as the best location for a new cardiac centre providing diagnostic and interventional cardiac procedures. This would provide care close to home for residents in the adjacent GTA/905 areas, increase capacity for cardiac catheterization procedures, build on current expertise in the region and establish a firm foundation for future cardiac services in GTA/905.[69]

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[67] PTCA refers to percutaneous transluminal coronary angioplasty, commonly known as angioplasty.

[68] The HSRC estimated volumes for cardiac centres using cardiac surgeries. It was assumed that coronary artery bypass graphs (CABGs) account for 75% of all open heart surgeries performed at a typical cardiac surgery centre. Projections for cardiac surgeries assumed that the target of 100 CABGs per 100,000 age and sex adjusted population (age 20 and over) would be achieved.

[69] In accordance with the Peel Region DHC recommendations, the HSRC recommended that the cardiac program be sited at the Mississauga site of theTrillium Health Centre. It was also recommended that the program develop a mentorship agreement with an established academic cardiac program.

- Need for an additional cardiac program in the east/north regions of the GTA/905 be assessed when the Peel site reaches 800 to 1,000 cardiac surgical cases per year.
- CCN and the MOHLTC to identify and address issues about accessibility to cardiac services. This process should include input from stakeholders beyond current cardiac centre representatives.
- The data system used to monitor access to cardiac surgery should be expanded to include cardiac catheterization and pacemaker services.
- There is sufficient "cath lab" and cardiac surgery capacity to meet projected needs in Central and Southwestern Ontario to the year 2003. Therefore, the HSRC did not recommend a cardiac centre for Waterloo Region.
- That CCN and the MOHLTC identify and address concerns about the timeliness and accessibility of tertiary cardiac services. The process should include waiting list protocols for diagnostic and interventional catheterizations as well as input from stakeholders beyond current cardiac centre representatives.
- The expansion of CCN's current cardiac surgery information system should include diagnostic catheterizations and interventional cardiology. This information system will:
  - monitor waiting lists and times
  - prioritize patients according to urgency for the procedure to ensure that those requiring care receive it within an acceptable time period
  - provide equitable access to care.

By 2003, capacity will be reached in Hamilton and London. CCN and the MOHLTC should start planning now to develop a strategy for the central west and southwest regions. The HSRC recommended that planning for the expansion of cardiac services should consider a new cardiac centre in central or southwestern Ontario as an alternative to expanding existing centres in London or Hamilton.

The HSRC did not accept the argument that a cardiac centre should be located in all communities that can provide the minimum volumes consistent with quality. Planning for tertiary services requires balancing quality, accessibility and affordability. Expansion in cardiac tertiary services should be done in a gradual manner over time to evaluate the effects on referral patterns, waiting times and capacity in existing centres that occur after the new cardiac centre in Peel region is fully operational. Consideration must also be given to human resources, including the provincial availability of the specialists required.

The Minister of Health has supported the establishment of a new cardiac service in Peel region at the Trillium Health Centre. In December 1998, the Minister also announced the government's plan to bring specialized cardiac services closer to home for residents of a number of additional communities including:

- Two new full service cardiac care centres (to be located in the areas of Waterloo/Wellington and York/Simcoe counties) to provide cardiac surgery, cardiac catheterization, coronary angioplasty, coronary stents and pacemaker services;
- A new cardiac catheterization laboratory in Peterborough serving the areas of Durham, Peterborough, Haliburton, Victoria and Northumberland.

# Section X:
# Legal Challenges

# SECTION X: LEGAL CHALLENGES

From the beginning, the HSRC's mandate was controversial. There was wide public interest in the restructuring process and much opposition to the closing of local hospitals. It is not surprising, then, that there were numerous legal challenges to the HSRC's *Directions*. Each challenge was different in that it was brought by stakeholders who opposed the HSRC's *Directions* for their own particular reasons. However, some common themes emerged.

The HSRC was served exceptionally well by its legal counsel, John Laskin and his colleagues of Torys. The pace and complexity of restructuring and its impact on the health community in Ontario demanded that legal advice be decisive and definitive, but be given with sensitivity to the enormous challenge confronting not only the HSRC but all participants in the restructuring process. The HSRC acknowledges the outstanding contribution of Mr. Laskin. His wisdom and guidance were greatly valued and appreciated.

The following is a summary of each of the court proceedings. The dates indicated are those of the court decisions.

## Sudbury General Hospital

(Divisional Court, January 1997)

The first challenge to the HSRC was brought by the Sisters of St. Joseph of Sault Ste. Marie ("the Sisters"), the owners and operators of the Sudbury General Hospital. The HSRC had issued *Directions* for the restructuring of the Sudbury General and the other two acute care hospitals in Sudbury into a single regional hospital. The Sisters challenged the *Direction* requiring them to give up control of their hospital. They applied for judicial review of the HSRC's *Directions* and brought a motion to stay the implementation of the *Directions* pending the decision on their application.

There were three grounds on which the Sisters asked for judicial review. They alleged:

(1.) that the *Directions* infringed their *Charter*-protected right to freedom of religion by requiring them to give up control of their hospital, which was a means of carrying out their religious mission;

(2.) that they were denied procedural fairness in the process leading up to the *Directions* because the HSRC had not granted them an oral hearing or provided them with copies of other parties' submissions; and

(3.) that one of the members of the HSRC was biased by reason of his previous involvement with another Sudbury hospital.

The Court dismissed the Sisters' motion to stay the *Directions*. The Court held that since the planning process for the new hospital was still under way and the deadline for closure of the Sudbury General was still in the future, the Sisters would suffer no irreparable harm if the process towards implementation of the *Direction* proceeded. The Court also reasoned that granting a stay would effectively suspend the hospital restructuring process, and frustrate the strong public mandate given to the HSRC. This would affect not just the Sisters and the HSRC, but also the general public, which had an important interest in the restructuring of the health system. The harm to the public interest in granting a stay therefore outweighed any harm the Sisters would suffer if a stay were refused:

> ***[T]he general public would be affected and not just the Sisters and the HSRC.... There is overwhelming evidence that hospital restructuring in the Sudbury area is long overdue.... The HSRC***

***acts under a strong public mandate. The general public has a significant investment in the hospitals in the Sudbury area and there are serious imminent financial, administrative and patient care concerns of hospitals in the area. These public concerns weigh more heavily than those of the applicants....***

The judicial review application itself was never argued. After the dismissal of the stay motion, the dispute was settled on terms that gave the Sisters a role in the new Sudbury Regional Hospital, managing the Sudbury General site pending consolidation of services by the new hospital and managing the new hospital's chronic, transitional/sub-acute and palliative care on an ongoing basis, both in accordance with their Catholic health care mission and consistent with governance of the new hospital's board.

## Brockville, Lakehead & London Psychiatric Hospitals (OPSEU)

(Divisional Court, April 1997)

The next series of challenges concerned the HSRC's authority to issue *Directions* to provincial psychiatric hospitals. In three separate instances, the HSRC had directed the closing of a local psychiatric hospital and the assignment of delivery of mental health services to nearby public hospitals. The HSRC also instructed the hospitals affected to negotiate human resources adjustment plans. Concerned by the impact of the *Directions* on its members, the union representing employees in each hospital commenced judicial review applications challenging the jurisdiction of the HSRC to give *Directions* with respect to psychiatric hospitals.

The applications were dismissed as unnecessary. The HSRC and the Ministry agreed prior to the hearing of the applications that the authority of the HSRC to give *Directions* to public hospitals did not extend under the legislation to provincial psychiatric hospitals, and that the *Directions* concerning these hospitals were and were intended to be treated as *advice* from the HSRC to the Minister of Health, who has ultimate control of these hospitals.

## Pembroke Civic Hospital

(Divisional Court, June 1997 and July 1997;
Court of Appeal, July 1997 and September 1997)

In February 1997, the HSRC issued *Directions* for the closure of the non-denominational Pembroke Civic Hospital and the transfer of its programs and services to the Pembroke General Hospital, a newer and larger facility, owned and operated by a Catholic religious order. The Civic and its supporters believed that it was unfair to close Pembroke's only non-denominational hospital and compel all area residents to receive hospital care in a Catholic institution. They were also of the view that the HSRC had given too much weight to Catholic health care interests. They therefore brought an application for judicial review to set aside the HSRC's *Directions*.

The application was based on three grounds:

(1.) that the HSRC exceeded its jurisdiction when it considered policy matters on the continuing role for denominational health care in Ontario;

(2.) that the HSRC had breached procedural fairness because it had not made full disclosure to the Civic of the submissions made to it by others, so that the Civic did not know the case that the hospital had to meet; and

(3.) that the *Directions* infringed the Charter-protected right to freedom of religion of the non-Catholic residents of the community. The applicants alleged that Catholic religious principles precluded Pembroke General from offering essential health services, including abortions and other services related to reproductive health, and that non-Catholics were entitled to obtain hospital services free from

the discomfort that would result from being treated in a Catholic environment.

As in the Sudbury case, the applicants sought a stay of the HSRC's *Directions* pending the hearing of their application. Initially, the hospital was scheduled to close before the application was to be heard. However, the dates for both the closing and hearing were changed so that the hearing took place one month before the revised closing date. The court therefore refused a stay, on the basis that no irreparable harm would occur prior to the hearing from any implementation steps short of closing.

The hearing of the application for judicial review then proceeded before the Divisional Court. The Court dismissed the application. Mr. Justice Archie Campbell, who wrote the reasons for judgment, began by emphasizing both the breadth of the HSRC's authority and the limited role of the Court.

> ***The Legislative Assembly ... and the government ... gave the [HSRC] a very strong mandate to restructure the Ontario hospital system.... The court's role is very limited in these cases. The court has no power to inquire into the rights and wrongs of hospital restructuring laws or policies, the wisdom or folly of decisions to close particular hospitals, or decisions to direct particular hospital governance structures. . .The law provides no right of appeal from the HSRC to the court. The court has no power to review the merits of the HSRC's decisions. The only role of the court is to decide whether the HSRC acted according to the law in arriving at its decision.***

The Court rejected each of the grounds put forward by the Civic and its supporters. It held that the HSRC had not exceeded its jurisdiction in considering the role of denominational health care in Ontario. As a policy-making body with wide discretion, the HSRC could take into account any information it deemed relevant when making decisions. The long history of denominational health care in the province was a factor that it was fully entitled to consider. Nor was there any lack of procedural fairness. As a policy-making body, not an adversarial forum, the HSRC was required to give hospitals affected by its decisions a fair opportunity to make submissions. But it was not bound to adopt the adversarial procedures of a court. The Civic Hospital knew the issues that the HSRC would be considering, and had a fair opportunity to address them. Finally, there was no infringement of the *Charter*. The *Directions* would have no impact on the availability of abortions in Pembroke, since no doctor in the community had performed abortions for many years. There was no evidence that the *Directions* would have any impact on availability of the other medical procedures that the applicants alleged would no longer be available. The fact that there were Catholic religious symbols displayed at the General would not breach the religious freedom of non-Catholic patients:

> ***The silent presence of crosses and crucifixes does not constrain the chosen religious practices of those exposed to them and does not compel or coerce them to engage in religious practices or observances which they would not freely choose.***

Immediately after the Divisional Court dismissed the application, the Civic applied for leave to appeal to the Court of Appeal and sought a stay of the *Directions* pending appeal, since the Civic's emergency department was scheduled to close under the *Directions* before the leave to appeal request would be decided. The Court of Appeal granted the stay, on the ground that the Civic should have the opportunity to pursue all legal remedies to challenge the *Directions* before they irretrievably took effect. However, the Court of Appeal later dismissed the motion for leave to appeal.

In many respects, this was the most significant court decision. It helped reinforce the mandate and authority of the Commission and laid the foundation for the consideration and deliberation of future legal challenges.

## Wellesley Central Hospital (Toronto)

(Divisional Court, June 1997 and September 1997)

In March 1997, the HSRC issued a *Notice of Intention to Issue Directions* to The Wellesley Central Hospital under which Wellesley Central would cease operation as a public hospital and relinquish the ownership, operation, management and control of the hospital's services, buildings and assets to St. Michael's Hospital, a Catholic public hospital. In the previous year, the Wellesley had voluntarily amalgamated with the Central Hospital and had pursued a voluntary alliance with Women's College Hospital.

At the same time as it made submissions to the HSRC concerning the *Notice of Intention*, the hospital also applied for judicial review, and sought to have the Divisional Court quash the *Notice of Intention* and prohibit the HSRC from issuing *Directions* in the same or similar terms. The HSRC moved to quash the application as premature. The court granted the motion and dismissed the application. It accepted the HSRC's submission that the *Notice of Intention* did not represent a final decision, and that Wellesley Central had the opportunity to make further submissions to the HSRC to try to influence its decision on the *Directions* that should be issued.

After reviewing the submissions made by Wellesley Central and others, the HSRC was not convinced that it should change its intended view and direct that Wellesley Central remain open. However, it varied the approach set out in the notice in a number of respects. In July 1997 it issued *Directions* requiring Wellesley Central to develop a plan with St. Michael's for the transfer to St. Michael's of the operation and management of its programs and services, and provide for the temporary use by St. Michael's (subject to the payment of appropriate compensation) of the buildings and assets of Wellesley Central required for patient care. The *Directions* also required that Wellesley Central submit to the Minister a plan for the disposition of the land, buildings and assets of the Wellesley site, once all programs were transferred.

The changes from the *Notices* did not satisfy the hospital. Wellesley Central and three patients of the hospital sought judicial review of the *Directions*. Their application was based on seven grounds:

(1) that the requirement to allow the temporary use of its site by St. Michael's and to submit a disposition plan for its site amounted to an expropriation of its property, which was beyond the power of the HSRC to direct;
(2) that the *Directions* were void for uncertainty because they did not specify the nature of the transfer plan that the hospitals were to develop;
(3) that the HSRC had improperly given too much weight to the health care mission of the Catholic Church;
(4) that the HSRC had violated its duty of procedural fairness by denying the hospital an oral hearing and full disclosure of documents;
(5) that the association of certain Commissioners and HSRC staff with other Toronto hospitals created a reasonable apprehension of bias;
(6) that the HSRC had improperly acted under the influence of the MOHLTC; and
(7) that the *Directions* infringed the *Charter* guarantees of freedom of religion, equality and liberty and security of the person by forcing patients living with HIV/AIDS to obtain treatment at St. Michael's in a religious atmosphere hostile to their lifestyle and beliefs and by depriving Wellesley Central patients of access to certain medical procedures, particularly those related to reproductive health, that a Catholic hospital would not offer.

The Court rejected each of these arguments. It held that the HSRC had the power under its general authority to give *Directions* to hospitals that it considered in the public interest and to require that Wellesley Central allow St. Michael's the temporary use of its site. It also held that there was no expropriation, but merely a direction that the hospital participate in a planning process, that might well lead to voluntary transfer of the hospital's property. Nor were the *Directions* void for uncertainty. Wellesley Central, like other public hospitals, had extensive experience in planning and should not require specific, detailed instructions to carry out the intent of the *Directions*. If assistance was required, it was available from Ministry guidelines, the facilitator appointed to assist with implementation or the HSRC itself.

As for the contention that the HSRC improperly gave too much weight to the interests of the Catholic Church, there was no evidence to support it. The HSRC was in any event fully entitled to consider the role of denominational health care when making its decisions. There was equally no failure to provide procedural fairness. As held in the Pembroke case, the HSRC, as a policy making body, was not required to adopt the adversarial procedures of a court. The hospital had an ample opportunity to put its views forward, and the HSRC had taken them into account.

On the allegation of reasonable apprehension of bias, the Court concluded that the hospital had failed to demonstrate that there was any pre-judgment of the issues on the part of the HSRC. It also pointed out that it was in the public interest to have qualified, experienced people on the HSRC and that it would be very difficult to find qualified people who did not have previous involvement in health care. The individuals named by the applicants had resigned their positions with the other organizations and had adhered to the HSRC's conflict of interest guidelines. The Court found, similarly, that there was no evidence to support the allegation that the HSRC had acted under the dictates of the Ministry.

Finally, the Court dismissed the applicants' *Charter* arguments as without factual foundation. There was no evidence that anyone would be compelled to receive treatment at St. Michael's. Treatment for HIV/AIDS as well as abortion and other reproductive services were available at several other hospitals as well as other health care facilities. St. Michael's itself was providing health care to people living with HIV/AIDS without religious influence, regardless of the sexual orientation of the patient.

## Doctors Hospital (Toronto)

(Divisional Court, September 1997)

In July 1997 the HSRC issued *Directions* requiring Doctors Hospital ("Doctors") to relinquish operation and management of its programs and services to The Toronto Hospital (TTH), a teaching hospital affiliated with the University of Toronto, and to work with TTH to develop a plan for the temporary use by TTH of the Doctors site until all Doctors programs and services were transferred to the Toronto Western site of TTH. The conclusion of the HSRC was that these *Directions* would strengthen the delivery of ambulatory care in downtown Toronto as well as ambulatory care training.

Doctors had strongly objected to this approach on the basis that it was a model ambulatory care hospital, and should be left alone, as recommended by the Metropolitan Toronto District Health Council, rather than taken over by TTH. It therefore sought judicial review of the *Directions* on a number of grounds. It alleged that:

- because the HSRC was bound by statute to "have regard to" DHC reports and restructuring plans, the HSRC had no authority to proceed with a different approach to restructuring;

- the HSRC had failed specifically to consider the public interest as it was bound by statute to do;
- the HSRC had improperly given too much weight to the interests of the University of Toronto and TTH;
- the HSRC had improperly delegated its powers by asking the President and Dean of Medicine at the University of Toronto to try to facilitate an agreed resolution between Doctors and TTH;
- there was a reasonable apprehension of bias because of the involvement of the President and Dean of Medicine of the University, who were members of the TTH board, and because Dr. Sinclair, the Chair of the HSRC, had given a speech favoring accommodating the needs of teaching hospitals;
- the effect of the *Directions* was an expropriation of the hospital's property, which the HSRC had no power to direct;
- the *Directions* were void for vagueness because they did not clearly specify what the hospital was to do to implement them; and
- the HSRC had breached its duty of fairness by not making known the case that the hospital had to meet, not giving the hospital notice of the information on which it based its decision and not holding public hearings.

The Court dismissed the application. It held that the HSRC had met its obligation to consider the DHC plan. The plan was in no way binding on the HSRC, which was fully entitled to change it as it saw fit in the public interest. As for the allegation that the HSRC had not specifically referred to the public interest, the Court found it obvious from the HSRC's reports that it had acted based on its view of what the public interest required.

The Court rejected the argument that the HSRC had erred by taking into account the views of the University. In exercising its mandate, the HSRC was authorized to consider any matter it deemed relevant. There was no delegation of functions to facilitators: in requesting the assistance of the President and Dean, the HSRC had surrendered none of its decision-making authority. Nor did their involvement suggest bias, since they played no part in the HSRC's decisions. Dr. Sinclair's speech was also not a basis for finding a reasonable apprehension of bias. It reflected only one of the visions of health care brought before the HSRC, and did not begin to demonstrate that the HSRC had a closed mind.

The provision for temporary use of the Doctors site, the Court held, was authorized under the HSRC's general power to give *Directions* related to hospitals that it considered in the public interest. Nor were the *Directions* vague and uncertain. Doctors had made no attempt to try to work out a plan to implement the *Directions*. Instead it had simply thrown up its hands and gone to court. Given the complexities involved, leaving it up to Doctors to plan how best to achieve the goal of transferring operations to TTH was preferable to the imposition of a detailed plan prepared by the HSRC.

Finally, there was no basis for the allegation of breach of the duty of fairness. The HSRC complied fully with its fairness obligations as determined in the Pembroke case by giving Doctors a fair opportunity to make its views known before the *Directions* were issued.

## Hôtel Dieu Hospital (Kingston)

(Divisional Court, October 1998; Court of Appeal, June 1999; Supreme Court of Canada, February 2000)

Like the Sudbury General Hospital, Hôtel Dieu Hospital (HDH), located in Kingston's downtown core, is operated by a Catholic religious order, the Religious Hospitallers of Saint Joseph ("the Sisters"). Before the HSRC began its work in Kingston, HDH had already participated in voluntary hospital restructuring. This had led to the transfer of most of its in-

patient services to Kingston General Hospital (KGH), a larger hospital located within walking distance of HDH, and its becoming primarily an ambulatory care hospital.

In June 1998, the HSRC issued *Directions* to the Kingston hospitals. The *Directions* called for the consolidation of all hospital services at two sites: the KGH site and the site of the Kingston Psychiatric Hospital (KPH) west of the downtown core, where a new academic health facility, including a new ambulatory care centre, was to be built. The *Directions* also provided for the unification of the governance of acute care services under the board of KGH. They therefore required that HDH relinquish to KGH the operation and management of the programs and services of HDH. However, the *Directions* also specifically contemplated an ongoing role for the Sisters in acute care in Kingston. They required KGH to change its by-laws to provide the Sisters with seats on its board. KGH was also directed to offer the Sisters an opportunity similar to that accepted by owners of the Catholic hospital in Sudbury: to manage the programs and services at the HDH site on an interim basis (i.e. pending their transfer), and to manage the new ambulatory care centre at the KPH site on an ongoing basis.

The Sisters objected to the *Directions*, and brought an application for judicial review. They alleged, first, that because the proposed use of the KPH site raised significant municipal planning issues and required the Minister's approval, it was not yet known whether the site would be available. To require them to relinquish operation and management of programs and services at the HDH site before it was known whether the site would be available for use was, they argued, unreasonable. Second, they alleged that the HSRC had acted illegally by failing to have regard for provincial policy statements issued under the Planning Act and the official plan of the City of Kingston. Third, they alleged that the Directions violated their freedom of religion under the *Charter* by preventing them from carrying out their religious mission to minister to the sick and poor in downtown Kingston.

The Divisional Court dismissed the application. It held that the *Directions* were not unreasonable. While there might be difficulties in implementing the *Directions*, requiring the HSRC to resolve all implementation issues before issuing *Directions* would be a *"recipe for paralysis"*. Should implementation problems arise, the HSRC could exercise its powers to amend or revoke a direction. Second, it held that the mandate of the HSRC gave it no authority to deal with municipal planning matters. It was therefore under no obligation to consider the provincial policy statements or municipal official plans. In any event, the evidence showed that it had done so. Finally, it held that there was no infringement of freedom of religion. The *Directions* did not preclude the Sisters from carrying out their religious mission in ways other than operating a public hospital with public funds. The Supreme Court had made it clear that freedom of religion does not include a right to public funding or other state support for religious activities.

The Sisters appealed the decision of the Divisional Court to the Court of Appeal. The Court dismissed the appeal. It agreed with the Divisional Court that, since the HSRC has no authority to deal with municipal planning matters, it was under no obligation to consider provincial policy statements or municipal official plans. There was, therefore, no need for the Court even to concern itself with whether in fact the HSRC had done so. Similarly, because municipal planning issues were not the responsibility of the HSRC, any implementation issues related to planning could not make its *Directions* patently unreasonable.

As for the Sisters' allegation of breach of freedom of religion, the Court saw the real effect of the *Directions* as terminating the public funding of HDH. There was no basis in law for the Sisters' position that the

long-standing public support for their hospital gave them a *Charter* right to have that support continue because of the hospital's religious foundation. "The great principle of freedom of religion," the Court stated, "does not guarantee public funding for denominational public hospitals."

The Sisters applied to the Supreme Court of Canada for leave to appeal on the freedom of religion issue. In February 2000, the Supreme Court dismissed their application.

## Hôpital Montfort (Ottawa)

(Divisional Court, November 1999)

Hôpital Montfort's primary working language is French. It serves a substantially francophone patient population and also provides a francophone milieu for the teaching and training of health professionals.

In February 1997 the HSRC issued a report and *Notices of Intention to Issue Directions* under which the Montfort would be closed and the hospital amalgamated with three other Ottawa hospitals. It was the Commission's view, based on the information it then had, that the proposed *Directions* would ensure both access to French language health services and a francophone teaching milieu. While the Montfort site would close, its acute care programs and services would form part of the new, amalgamated hospital, where they would add to the services already being provided in French by the Ottawa General Hospital.

The proposed closing of Montfort generated a strong response. After reviewing the submissions received, and undertaking further consultations and analysis, the HSRC issued *Directions* in August 1997 providing for Montfort to remain open, retain its own governance and to continue both to provide services to the francophone community and serve as a francophone teaching milieu. The HSRC determined that the services provided at Montfort should be reconfigured. The hospital should provide ambulatory care and day surgery, operate a 24-hour urgent care centre and operate 66 beds for low-risk obstetrics, acute mental health and long-term mental health care. The HSRC directed that other programs be transferred to other hospitals, which would be designated to provide services in French under the French Language Services Act. In July 1998, the HSRC issued further *Directions* that allocated 22 sub-acute care beds to Montfort in addition to the beds allocated in the August 1997 *Directions*. The HSRC was satisfied that the *Directions* would maintain and enhance services to the francophone community and that, in this revised configuration, Montfort would continue both to play an important role in the provision of French language health services and to provide a francophone milieu for the training of health care professionals.

Montfort brought an application for judicial review to quash the *Directions*. It based its claim on four grounds. It alleged that:

(1.) The *Directions* violated the *Charter*'s equality rights guarantee by discriminating against Franco-Ontarians. The effect of the *Directions*, it argued, would be to deprive the Franco-Ontarian community not only of access to acute care services in French and the opportunity to train in French, but also of an institution essential to the survival of the community;

(2.) Even if there was no breach of the *Charter*, the *Directions* violated the unwritten constitutional principle requiring respect for minorities because of their impact on the Franco-Ontarian community;

(3.) In issuing the *Directions* the HSRC had taken into account the possibility of an anglophone backlash, and thus exceeded its jurisdiction by basing its decision on irrelevant considerations; and

(4.) The *Directions* were patently unreasonable. It submitted that, given the facts relating to the provision of services at other hospitals designated under the French Language Services Act and the services that would remain at Montfort, it was irrational for the HSRC to conclude that its *Directions* could ensure the provision of services in French, and an adequate francophone teaching milieu since the designated bilingual hospitals have been unable to provide adequate health care services in French to date.

Montfort's application was heard before a bilingual panel of the Divisional Court in June 1999. The Court released its decision in November 1999. The Court dismissed the *Charter* claim. It accepted the HSRC's argument that the minority official language rights guarantees set out in the *Charter* confer no right to francophone health services or medical education, and that the *Charter's* equality rights guarantees may not be used to enhance language rights beyond what is specifically provided for. It also concluded that the *Directions* were not based on any notion of anglophone backlash, and that they were not patently unreasonable. It recognized the broad policy mandate of the HSRC and the limited scope for judicial review of its decisions. It accepted that the Commission had acted on the evidence and material presented to it, and applied its policy criteria related to the quality, affordability and accessibility of health care in the region on the HSRC's assessment of the needs of the community.

However, the Court determined that the *Directions* violated the unwritten constitutional principle of protection of minorities. This principle, it stated, had been recognized as one of the fundamental organizing principles of the Constitution. Government action must therefore comply with it, and the courts must intervene if government action does not comply. In finding that the *Directions* violated this principle, the Court focused on the role of Hôpital Montfort as a symbol of francophone minority culture. It acknowledged that the HSRC had recognized the importance of maintaining French language medical services and training, and had made genuine efforts to do so. However, it found that the HSRC had seen these needs only in terms of the provision of bilingual services, and failed to address the necessity for homogeneous francophone institutions. The HSRC was constitutionally bound, it stated, to consider and give effect to the role of Montfort as a truly francophone institution, and to take into account the broader issue of protection of and respect for francophone cultural minority rights. The Court concluded that the changes to Hôpital Montfort contemplated by the *Directions* would have a significant negative impact on the continuing vitality of the language and culture of the Franco-Ontarian community. It therefore quashed the *Directions* and remitted the question of restructuring of health services at Hôpital Montfort to the HSRC for reconsideration and recommendation to the Minister of Health.

In March 2000, the Ontario Court of Appeal granted the HSRC's motion for leave to appeal from this decision. The Attorney General of Ontario is proceeding with the appeal.

## Douglas Memorial Hospital (Fort Erie)

(Superior Court of Justice, November 1999)

Douglas Memorial is a rural public hospital located in Fort Erie, in the Niagara Region. In March 1999, the HSRC issued *Directions* calling for Douglas Memorial to amalgamate with eight other hospitals in the Region to form the Niagara Health Care System. To ensure local input into decision-making for smaller communities in the Region, it also directed that the amalgamated hospital establish standing committees for Fort Erie and the other communities with rural hospitals. Any decision to eliminate in-patient or emergency services at a rural hospital requires approval of the standing committee. This approval, however, could not be unreasonably withheld.

In June 1997, the MOHLTC had published its *Rural and Northern Health Care Framework*, setting out the Ministry's policy for health services in rural and northern hospitals. The HSRC considered the Framework in determining its own approach to restructuring in these areas. Under this approach, rural and northern hospitals were grouped into networks and asked to report to the HSRC on services and organizational and clinical linkages. The HSRC did not apply the governance elements of this approach to rural and northern hospitals in Niagara and other parts of the province where it had already begun its review and where DHCs had already completed their consideration of restructuring. Instead, it completed its consideration of governance arrangements for these hospitals and issued *Directions*, taking the Framework into account in doing so.

Douglas Memorial, a rural hospital under the Framework, had made representations to the HSRC that it would be consistent with the Framework for it to retain its own governance. Following the issuance of the *Directions*, it sought judicial review of the *Directions* requiring it to amalgamate. It argued that the HSRC was bound by the Framework which meant rural hospitals were to be left to determine their own governance arrangements. It also argued that the *Directions* were discriminatory because they did not treat Douglas Memorial in the same way as the other rural hospitals to which the HSRC had not given governance *Directions*.

Because of the impact of the application on the restructuring process in the Niagara Region as a whole, it was agreed that it would be heard on an urgent basis by a judge of the Superior Court. The Court dismissed the application. It found that nothing in the Framework sought to prohibit the HSRC from giving rural hospitals *Directions* on governance, or limit its mandate to restructure hospitals according to its assessment of the public interest. In any event, the HSRC was not bound by the Framework. At the time it issued the *Directions*, the HSRC had broad powers to restructure hospitals throughout the province in the public interest. The Framework was not a regulation and did not amend the legislation giving the HSRC its powers. The Court also rejected the contention that the HSRC acted in an arbitrary or discriminatory manner. It stated that the HSRC was fully authorized to make the decisions for each individual hospital that it determined to be in the public interest. Its decision on Douglas Memorial was made in good faith, with regard to the public interest and without improper motive.

It summarized its decision as follows:

> ***The Commission has made a decision to replace the governing board of Douglas with a standing committee in a larger governing body. That decision was made in the exercise of the Commission's mandate in good faith. It is not discriminatory ... I find that the Commission is not bound by the Framework. The final decision-making power rests with the Commission. In the final analysis, this decision making power is not fettered by the Framework.***

Douglas Memorial brought a motion for leave to appeal to the Ontario Court of Appeal. That motion was dismissed in January 2000.

# Section XI:
# Changing Hospital Landscape

## Monitoring of HSRC Directions and Restructuring
## General Implementation Issues
## Community-Specific Implementation Issues

# SECTION XI: CHANGING HOSPITAL LANDSCAPE

Though much remains to be accomplished in implementing the HSRC *Directions*, the health care landscape in Ontario will be different once the restructuring components have been put in place. In total, 22 communities received *Directions* (see Figure XI-1). Some of the characteristics that will shape the new health environment as a result of the HSRC's *Directions* and advice to the Minister include:

- Amalgamation of a number of hospitals to form new, fewer but larger organizations
- Closure of 31 public hospitals, six private and six provincial psychiatric hospital (PPHs) sites
- Takeover of four hospitals by other hospital corporations
- Creation of 10 joint committees to provide shared governance to multiple organizations
- Creation of 18 rural/northern hospital networks
- Establishment of a variety of regional and provincial networks (including child health networks in Ottawa, Toronto and London; rehabilitation networks; and, a French language services network in Ottawa).

It is expected that the implications of executing all these reforms, in addition to the reinvestments prescribed by the HSRC to support their implementation, will result in:

- Removal of excess hospital bed capacity
- Better use of capital resources
- Rationalization of hospital programs and services
- Creation of multi-institutional organizations with a single governance structure
- A more appropriate balance of institutional and community-based care
- Increased hospital capacity through enhanced efficiencies, resources, emergency room and ambulatory capacities
- Expansion of home care and long-term care, enabling hospitals to focus on the accommodation of acutely ill patients
- Incorporation of a population needs[70] approach in developing planning guidelines for reinvestment
- New resources and funds
- Identification of data needs and limitations
- New networks focussed on building a better continuum of care
- Developing new funding tools and mechanisms to support further health system development in the future.

[70] This refers to methodologies that take into consideration age, sex and other characteristics of the population.

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**Figure XI-1: Communities issued Directions by the HSRC**

| County/Communities | Date Of Final Directions |
|---|---|
| Brant | May 20, 1998 |
| Essex (Windsor) | February 12, 1998 |
| Frontenac, Lennox & Addington (Kingston, Napanee) | June 23, 1998 |
| Greater Toronto Area/905 (Durham, Halton, Peel, York) | April 27, 1998 |
| Haliburton, Kawartha, Pine Ridge (Peterborough, Lindsay, Port Hope, Cobourg) | June 19, 1998 |
| Hamilton-Wentworth | May 20, 1998 |
| Hastings, Prince Edward (Belleville, Trenton, Picton, Bancroft) | April 30, 1998 |
| Kent | February 11, 1998 |
| Lambton (Sarnia, Petrolia) | October 1, 1997 |
| Leeds & Grenville (Brockville) | February 4, 1998 |
| London | June 16, 1997 |
| Metro Toronto | July 23, 1997 |
| Niagara Region | March 9, 1999 |
| North Bay | March 11, 1999 |
| Ottawa-Carleton | August 13, 1997 |
| Parry Sound | December 7, 1998 |
| Renfrew (Pembroke) | February 25, 1997 |
| Sault Ste. Marie | March 10, 1999 |
| Stormont, Dundas, Glengarry, Prescott & Russell (Cornwall) | August 10, 1998 |
| Sudbury | December 16, 1996 |
| Thunder Bay | October 4, 1996 |
| Waterloo (Kitchener, Waterloo, Cambridge) | August, 1998 |

The HSRC made the following observations regarding the changing hospital/health care landscape:

**There is an informed audience throughout the province that recognizes health system change is essential, and that difficult decisions must be made.**

Recognition that tough decisions were overdue, however, did not deflect criticism of the HSRC's agenda. Although the majority of health providers, consumers and health administrators agree health care can be improved as a result of hospital restructuring, many are opposed to closing the hospital or the services of the hospital they themselves work in or use.

**Many communities have the desire and willingness to embrace change to prepare themselves better for the future. However, people are generally resistant to change and thus, do not manage change easily or quickly.**

Most of the HSRC's *Directions* were well received in private. There was, for example, frequent acknowledgement that the HSRC's approach and decisions were in line with the views of many of those in communities reviewed by the HSRC. However, public support was frequently silent or muted. In some cases initial support turned to opposition when provoked by institutions seeking to protect their 'turf'.

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| | Date Of Final Directions |
|---|---|
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| [redacted] | February 12, 1998 |
| [redacted] | June 23, 1998 |
| [redacted] | April 27, 1998 |
| [redacted] | June 19, 1998 |
| [redacted] | May 20, 1998 |
| [redacted] | April 30, 1998 |
| [redacted] | February 11, 1998 |
| [redacted] | October 1, 1997 |
| [redacted] | February 4, 1998 |
| [redacted] | June 16, 1997 |
| [redacted] | July 23, 1997 |
| [redacted] | March 9, 1999 |
| [redacted] | March 11, 1999 |
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**Turf protection continues to be prevalent in the health system.**

Although the restructuring debate dealt primarily with issues related to the accessibility, quantity and quality of health services to be provided, debates frequently turned to the matter of *who* is to provide the service and *where* it will be provided. As opposed to considering services from the perspective of what is best for patients, some took a narrow approach focused on defending the interests of a specific institution and/or population.

Arguments about turf and who will be 'in charge' were couched in the language of concern for the health of particular groups. The self-interest of turf protection was also reflected in a number of written submissions received by the HSRC as well as public debates initiated by certain institutions. In fact, many debates were fuelled by the unwillingness of those in power to "give it up" and a desire to obtain power by those who were without it.

**Restructuring is not 'business as usual' for the health system or government**

Restructuring calls for decisive action and change in approach by the provincial government and the health system. It is not about cost cutting. Restructuring involves health system redesign to reflect contemporary circumstances and anticipated changes together with better utilization of resources to preserve and enhance patient services. Changing demographics, new technology, and aging buildings and equipment are some factors that led to the need for restructuring and new solutions. Restructuring requires people, government and health care organizations to change their attitudes, be open to new approaches and alliances, and adapt to different circumstances.

**Some hospitals have taken up the challenge of restructuring; others have resisted.**

In contrast, however, some hospitals opposed change and tried to maintain the status quo instead of seeking opportunities to engage in new partnerships, strategies and alliances.

**There is a need to rebalance health services through reinvestment in community-based services, such as home care and long-term care.**

The impact of the HSRC's restructuring efforts called for:

- the addition of approximately 17,000 new long-term care beds in nursing homes and homes for the aged (by 2003)
- additional capacity in emergency rooms to treat 19 per cent more patients (in 2003 than in 1995)
- capital reinvestment in the amount of approximately $2.1 billion in renovations to create upgraded, modern facilities in Ontario's restructured hospitals.

Delays to date in the flow of reinvestment funding have already effected restructuring. Continued delay will have the potential to undermine the overall restructuring initiative.

**Data and information to determine levels of health services are almost non-existent.**

Hospital restructuring has been guided by credible 'benchmarks' because hospital data (although primarily confined to in-patients) is by far the best in the so-called 'system'. However, there are vast shortcomings, fluctuations and concerns regarding data related to other sectors of the health system (e.g., ambulatory hospital care, home care, institutional long-term care, rehabilitation, mental health). In particular, the lack of the following are notable:

- a classification system and data standards that are relevant for in-patient, out-patient, and in-home services across the sectors
- a method or mechanism for standardized data collection and analysis
- data on services utilization
- data on outcomes
- data and supporting mechanisms to promote linkages between in-patient, out-patient and in-home providers
- data and mechanisms to facilitate integration across the sectors (i.e., acute, rehabilitation, long-term care).

Accordingly, the HSRC spent much time and energy developing 'planning guidelines' and 'benchmarks' to guide the re-balancing of investment in other sectors of the health system that would support changes in the acute sector.

**The need for system leadership continues to grow and to become more evident as a vehicle for planning and securing future changes in the system.**

In general, Ontario's health services function well. However, the silo approach of the first decades of Medicare must now change. An essential driving force to ensure the creation of a true health services system is leadership — system governance — from the MOHLTC.

Rather than short-term solutions or strategies that have the usual four-year government mandate, longer-term approaches are needed. The changes required are profound, both in terms of organization and attitudes. The MOHLTC has a key role to play in providing leadership and, in fact, governance of the province's evolving health system.

**Change needs more time than can be undertaken/ achieved in a single government mandate.**

Many stakeholders believe that a high-profile body (similar to the HSRC) with clear responsibilities, but with a mandate beyond the term of government is needed to assume responsibility in specific areas. For example, this body would oversee the restructuring activity at all levels (with the authority to hold other components of the system responsible and accountable for their roles in implementation). It would also steer action on primary care reform and other reforms needed to ensure continued evolution of the health system. This issue is discussed further in Section XIII.

## Monitoring of HSRC Directions and Restructuring

The HSRC issued its final *Directions* to hospitals on March 12, 1999. At the beginning of April 1999 the HSRC undertook a project to determine the status of implementation in each of the communities where *Directions* had been issued. The objectives of this initiative were:

1. To determine the issues slowing down implementation of HSRC *Directions*.

2. To determine which communities were voluntarily moving forward with implementation, and which required some intervention to move them forward more quickly.

3. To set the stage for discussions with the MOHLTC about future roles and responsibilities of both the HSRC and the MOHLTC regarding ongoing monitoring of restructuring activities related to HSRC's *Directions* during the remaining HSRC mandate.

The HSRC stated from the outset that implementing restructuring was the responsibility of local providers. While this vested responsibility with those who were accountable for services, it was also clear there was a need to monitor, co-ordinate and in some instances, facilitate, the resolution of conflict locally.

As early as 1996, the HSRC approached the MOHLTC concerning appropriate processes and mechanisms to ensure monitoring of, and compliance with, HSRC *Directions*s. In October 1997, the MOHLTC announced the establishment of the Health Reform Implementation Team (HRIT), a new unit within the then-division of Institutional Health and Community Services Group of the Ministry. The HRIT was created to serve as a focal point in the Ministry to:[71]

- Co-ordinate and facilitate execution of the HSRC's *Directions* and advice
- Manage HSRC directed and interdependent projects
- Determine hospital funding allocations in partnership with the Institutional Health Division
- Co-ordinate mental health reform activities
- Link with Management Board Secretariat on human resources planning and the Ontario Realty Corporation regarding property and assets
- Link with the Laboratory Restructuring Secretariat to integrate laboratory reform with hospital restructuring
- Develop common templates and frameworks (e.g., to support program transfers, determine hospital funding allocations, assets/transfers agreements, etc.)
- Work closely with other areas of the Ministry to ensure restructuring occurs in a timely and appropriate manner.

HRIT staff was also responsible for identifying barriers common to local restructuring and working with stakeholders to resolve them.

As a result of regulatory changes (Ontario Regulation 272/99) made in April 1999, the Commission's binding powers to restructure hospitals were removed; from that point the Ministry had sole responsibility for issuing any further *Directions* to hospitals (see Appendix B). The HSRC, however, was expected to play a continued role in restructuring activities by providing advice to the Minister on hospital restructuring issues identified by the Ministry, including the need to revise or otherwise modify *Directions* or *Notices of Intention*.

A protocol agreement was established between the HSRC and MOHLTC in the fall of 1999. The general principles governing this protocol were:

- The Ministry wishes to ensure that the *Directions* of the HSRC are implemented;
- The HSRC (as of April 1, 1999) became solely an advisory body to the Ministry; and,
- Communication to the field concerning changes to the *Directions* or new *Directions* would be made by the Ministry.

The agreement confirmed changes that were reflected in the regulatory amendments (April 1999); in particular, that the MOHLTC had the authority and overall responsibility for:

- Monitoring implementation of the HSRC's *Directions*; and
- Issuing *Directions*, supplementary *Directions*, notices, and supplementary notices to hospitals (however, agreement that MOHLTC would seek the advice of the HSRC prior to changing *Directions* issued by the HSRC, or issuing additional *Directions*).

[71] Correspondence to hospital administrators, the OHA, DHCs and the HSRC from the Assistant Deputy Minister, Institutional Health and Community Services, MOHLTC, October 30, 1997.

However, throughout the duration of its mandate, the HSRC was to also expected to continue to monitor implementation and be responsible for:

- Advising the Minister where further or amended *Directions* may be required;
- Providing confidential written advice to the Minister of Health on changes necessary to successfully implement hospital restructuring.

During this period, the Ministry and the HSRC also engaged in discussions and worked on the development of guidelines to effect the gradual transfer of responsibility for implementation to ensure continuity beyond March 2000.

## General Implementation Issues

As part of its review concerning the status of implementation of Commission *Directions*, the HSRC identified a number of issues, which were slowing the pace, and success, of restructuring. These issues were as follows:

**Mental health reform:** Lack of clarity from the MOHLTC regarding the following issues:

- Implementation of the Mental Health Implementation Task Forces (MHITF) [as advised by the HSRC]
- Lack of certainty regarding transitional mental health reinvestments
- Slow progress in resolving the labour adjustment issues that were impeding the divestment of PPHs and the transfer of their services to other public institutions.

**Rehabilitation:** Lack of a policy framework to co-ordinate realignment of rehabilitation services, particularly in Metropolitan Toronto and the GTA/905 region.

**Complex continuing care:** Lack of joint planning between the MOHLTC, CCACs and affected chronic care hospitals to help re-balance services from chronic to long-term care facilities.

**Long-term care and home care reinvestments:** Differing views on the 'adequacy' of the level, amount and pace of reinvestments in this sector.[72] In particular, concerns about:

- Lack of investment of operating dollars in long-term care facilities to cope with increased acuity of residents
- Delays in moving to a single (unified) classification system for determining eligibility and placement into LTC facilities (including complex continuing care beds)
- Lack of a decision by the MOHLTC to expand the role of CCACs to include placement to complex continuing care beds in addition to their current role of co-ordinating and facilitating placement of residents in nursing homes and homes for the aged and/or access to other iong-term care services
- Delays in building of 'new' facility-based beds.
- Availability of home care. In particular, related to quality, access, and the appropriate level of care and services required in each community to meet local needs.

[72] On several occasions, the HSRC recommended that the MOHLTC reconcile the appropriateness of its current planned reinvestments against the HSRC's recommendations and the experiences of stakeholder and provider groups who were directly impacted by the changes unfolding in hospitals across the province.

## Community-Specific Implementation Issues

There were a number of specific issues also identified in individual communities where progress on the implementation of restructuring was slow. Most of these issues required either direct intervention by the MOHLTC to break 'gridlocks' and/or a decision by the courts regarding ongoing legal challenges.

In particular, in the Fall of 1999, the HSRC identified the following communities as those where the pace of restructuring had been slow and/or complicated by local circumstances: Brant County; Frontenac, Lennox & Addington (Kingston); GTA/905; Hamilton-Wentworth; Niagara Region; Ottawa-Carleton (The Montfort); and Thunder Bay. As the HSRC concludes its mandate, its remains particularly concerned about the lack of progress on restructuring in Thunder Bay; primarily as related to the development of the new Thunder Bay Regional Hospital.

# Section XII:

# Building a Health Services 'System'

## Achieving the Vision: Moving Integrated Systems Forward

## Identifying Strategic Priorities: Environmental Considerations

## 'System-building': A Seven Point Action Plan

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# SECTION XII: BUILDING A HEALTH SERVICES SYSTEM

Between 1996-99 the HSRC focused its attention on restructuring the hospital sector. During the last year of its mandate (1999-2000), the Commission was engaged in two main activities:

1. *Putting mechanisms in place to ensure restructuring activities are regularly monitored and evaluated (i.e., follow-up to Phase 1 of HSRC mandate); and*

2. *Providing specific advice to the Minister of Health on priorities for restructuring the health system as a whole (Phase 2 of HSRC mandate).*

The latter focused primarily on elaborating on a vision for the future health system, and identifying specific strategies that would promote greater 'systemization' (i.e., 'system-building') in the system.

## Achieving the Vision: Moving Integrated Systems Forward

> **System: A set of interdependent, interacting elements; a group of units so combined as to form an organized whole whose output is greater than the output of the constituent units would be were they to function independently.**[73]

Currently, there is no co-ordinated 'system' of health care in Ontario. Hospitals, other facilities, agencies and health professionals do interact and work together at a number of levels. However, there is no identifiable 'system' or overall 'structure' to assist and support health providers and organisations to function together in an integrated fashion for the benefit of patients, populations and communities. In fact, there are many impediments to the functional collaboration of the several 'elements' necessary to make a real health services system.

Much of the HSRC's work during Phase 1 of its mandate addressed *horizontal integration* within the hospital sector.[74] In several communities this involved bringing together two or more hospitals, often with overlapping programs and services serving the same geographic population. Another result of the HSRC's Phase 1 activities has been to initiate evolution of *vertical integration* of hospitals of dramatically different sizes, covering significantly different catchment areas, offering programs ranging from primary care services through to complex tertiary care.[75] A consequence for many of the new boards is that their governance responsibilities encompass regional, in addition to local, hospital-based services.

Although the integration and co-ordination of hospitals has received broad support, there remains much less consensus on the concept and best approach to achieve vertical integration within the 'system' (i.e., hospitals with home care with long-term care with primary care, etc.).

[73] Khandwalla, Pradip N. *The Design of Organizations*.1977

[74] Horizontal and vertical integration are two ways restructuring has been approached: horizontal integration to connect comparable players involved in the delivery of similar services, and vertical integration to connect different players along a continuum of services.

[75] An example was the amalgamation of the four hospitals in the Durham Region to create the Lakeridge Health Corporation. Five facilities now serve an extensive catchment area ranging from the urban regional centre in Oshawa offering tertiary care, to the rural community hospitals in Uxbridge-Port Perry.

# SECTION XII: BUILDING A HEALTH SERVICES SYSTEM

Between 1996-99 the HSRC focused its attention on restructuring the hospital sector. During the last year of its mandate (1999-2000), the Commission was engaged in two main activities:

1. *Putting mechanisms in place to ensure restructuring activities are regularly monitored and evaluated (i.e., follow-up to Phase 1 of HSRC mandate); and*

2. *Providing specific advice to the Minister of Health on priorities for restructuring the health system as a whole (Phase 2 of HSRC mandate).*

The latter focused primarily on elaborating on a vision for the future health system, and identifying specific strategies that would promote greater 'systemization' (i.e., 'system-building') in the system.

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***For the most part, discussions of vertical systems integration — the foundation of building a better health system in Ontario — have been limited largely to the "spin-off" initiatives resulting from hospital restructuring. In particular, they have focused on the need for reinvestment in some of the other sectors, home care and long-term care especially. The broader task of vertically integrating the many silos in the health system, however, is key to achieving the vision of the future health system.***

The draft vision document released by the HSRC in January 1997 contemplated the establishment of formalized integrated health systems (IHSs) in Ontario.[76] The HSRC has continued to support the need for better linkages between health organizations and providers leading to the creation of an integrated, interactive and dynamic system providing patients with a more "seamless" continuum of care delivery. But it also recognized that formal IHSs in Ontario (however desirable they may be) can not be created in the near term given the magnitude of the current changes under way in the system as well as the constraints of the external environment.

***Although the HSRC is no longer advocating the establishment of formal IHSs in the near term, their establishment should remain a long-term goal. The Commission is convinced that greater co-ordination and integration of all health services is essential if more accessible, higher quality and cost effective health care delivery and improved health status are to be achieved. The challenge was to determine which opportunities held the greatest potential for:***

- ***Building on current reforms***
- ***Continuing to rebalance the various components/elements within the system***
- ***Integrating care, and***
- ***Achieving greater continuity of care.***

The Minister of Health wrote to the Commission in April 1998 requesting that consideration be given to undertaking the following as part of its Phase 2 work:

- Development of a paper on integrated models
- Exploration of the relative merits of capitation
- Advice on the implications of IHSs for the conceptual design of a health information management system
- Development of further benchmarks related to the measurement of 'quality' in the broader health system

To help the HSRC identify specific priorities to achieve greater 'systemization' in the health system, consideration was given to the work done and lessons learned during the hospital restructuring phase (Phase 1) of the Commission's mandate. In addition, the HSRC undertook a series of background studies to learn more about the following key forces shaping the external environment:

the ***political and regulatory*** environments including –

A. A review of legislative/regulatory implications for establishing IHSs
B. Advice from an expert panel on 'positioning' future change in the health system

the ***provider environment*** including –

A. Round table discussions with key stakeholder groups in the province to solicit feedback on what the priorities and next steps should be in reforming Ontario's health system

the ***public*** (consumer) ***environment*** including –

[76] In its vision document (1997) the HSRC described the future Ontario health system as a "series of inter-connected health systems and integrated academic health systems." These systems, comprised of groups of hospital and community health organizations, would be responsible for the health care of a defined population.

A. An assessment of the current changes under way in the system based on an analysis of public opinion on current health system reforms and a review of public behavior, perceptions and priorities.

The key findings resulting from the environmental review are outlined briefly below.

## Identifying Strategic Priorities: Environmental Considerations

### The Political and Regulatory Environments

#### A. Review of legislative/regulatory implications

In the summer of 1999, the HSRC reviewed the legislative changes that *might* be required to support the development of IHSs in Ontario. The review was structured around *seven minimal characteristics* that were identified to be fundamental to the development of IHSs. These included:

1. Scope of service
2. Financial and organizational flexibility
3. Roster of enrolees
4. Information systems
5. Funding
6. Relationship to fee-for-service
7. Primary care focus.

In summary, the HSRC suggested that legislative changes would be either desirable or, in some instances, necessary to:

1. Establish and regulate IHSs
2. Provide for the governance and management of IHSs
3. Authorize IHSs to allocate public funds
4. Authorize IHSs to exercise regulatory authority
5. Authorize IHSs to provide health services
6. Facilitate amalgamations of various types of health care providers to form IHSs
7. Facilitate alliances or partnerships between various types of health care providers to form IHSs
8. Address individuals' access to services (depending on the conditions, if any, attached to receiving health services from an IHS)
9. Facilitate appropriate payment arrangements for services provided by or through IHSs
10. Address the potential limitations on membership of the boards of IHSs arising from their charitable status, and
11. Provide for appropriate sharing and protection of personal health information.

Each of these changes was reviewed by the HSRC in a discussion paper. [77] The HSRC concluded that:

- The "bigger" barriers (barriers more complex and controversial to overcome) were more likely related to issues of governance, leadership, and political will than to legislation/regulation.
- Although much could be done without legislative levers given "good will", there is no *real* legal authority currently in place in Ontario to establish IHSs.
- Achieving greater vertical integration in the system is hampered by restrictions that prevent the Minister from delegating his/her powers over resource allocation.[78]

[77] HSRC. *Implementing integrated health systems in Ontario: a review of legislative/regulatory implications*. A discussion document. July 1999.

[78] For example, a key lever required to put IHSs in place relates to the devolution of authority to distribute money allocated by the Provincial Legislature under the 'vote' system to third parties or to make regulatory decisions at any level below the Minister of Health.

**B. Expert opinion on 'positioning' future change in the health system**

On April 9, 1999, representatives of the HSRC met with an international panel of experts to explore some of the *political* and *stakeholder* issues that should be considered when planning and implementing future health reforms.

The consensus of the panel was that while Ontarians may not be "opposed" to future health reforms, creating greater 'systemization' through the development of a more integrated health system in the province should be pursued in an evolutionary, as opposed to a "big bang", approach. Other strategies identified to be important to support the change process were as follows:

- **Solicit support from providers for integration/systemization.** Physicians, nurses and other health professional providers remain the most respected voices in forming public opinion on health care. Members of the public will seek the views of these provider groups on integration and will be more influenced by health professionals than by communication with government or planning bodies. Therefore, winning support of health professionals for systemization is critical.

- **Undertake a consultative process about the 'new model(s)' to establish a wide consensus on future change.** Any model thrust on an unsuspecting public through a unilateral, formal and binding government-mandated process will not succeed.

- **Focus on clear and specific goals, objectives and strategies in the consultation, rather than abstract principles or aspirations.** The release of a policy document with a series of specific proposals for broad public debate that describe the intended outcomes of change is recommended. Preferably, the document should take the form of a report to the government (from an advisory council or other arms-length body).

- **Develop a strategic and tactical communications plan for each recommendation to launch the debate effectively and avoid its being derailed prematurely by negative stakeholders and media comment.**

- **Build broad consensus during the consultative process through the technique of deliberative democracy[79] at the community level.**

Figure XII-1 summarizes some of the other considerations arising from the discussion with the expert panel regarding the positioning of future system change.

**Figure XII-1: Developing recommendations for future health system reform: key considerations**

| | |
|---|---|
| **Public concerns and preferences** | • Are the proposed changes clear, explicit and specific?<br>• Do the changes reflect/take into consideration the 'spirit and reality' of the Canada Health Act? If not, how will this be addressed?<br>• Are the proposed changes incremental?<br>• Has clear and precise testing of terminology been done?<br>• Does the proposed reform address public perception/concerns constructively? |
| **Stakeholders and process** | • Who is on side to help support the change?<br>• What process(es) will be used to build support and legitimacy for the change?<br>• Does the reform promote building momentum for change from the ground up? |

[79] The deliberative democracy model involves development of positive agenda goals to achieve consensus in subgroups of stakeholders and providers in a way that is supportive of community legitimacy.

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| | |
|---|---|
| **Process of policy reform** (development and implementation) | • Is the project positioned as legitimate and credible?<br>• What will be done to build receptivity for change?<br>• Does the initiative build momentum around a continuum of care?<br>• What aspects of the change will move furthest most quickly?<br>• Will the change help increase an individual's sense of control over their own health?<br>• In what way does the reform encourage creation of a parallel/alternate path?<br>• Are there incentives to shift to the new path?<br>• Will there be transition funds available to support the change? |

## The Provider Environment

**A. Round table discussions: next steps for health services restructuring**

- ***What are the three most important issues that must be addressed to move health system restructuring forward?***
- ***What are the key actions to be taken/incentives put in place to recruit enthusiasm for resolution of these issues among provider and professional groups in the province?***
- ***What process(es) should be put in place to ensure appropriate communication and consultation with provider and professional groups in the province in planning and implementing the next steps for health reform?***

In early 1999 the HSRC approached a number of individuals/organizations and invited them to convene groups of stakeholders in their respective fields to solicit feedback on these questions. A total of 18 round table discussions were held (involving approximately 180 participants). Each group was asked to submit a report to the HSRC summarizing the key issues that emerged.

Five overall themes were identified for planning future health system reforms. These were:

1. **Vision:** State and communicate a vision of health reform.
2. **Integration:** Eliminate silos and enhance integration.
3. **Primary care:** Make primary health care the foundation of future reforms by positioning it as the 'connector' to the rest of the system.
4. **Information infrastructure:** Invest in accessible information technology infrastructure.
5. **Incentives:** Align incentives among health care providers and consumers to improve accountability at all levels, and to stimulate 'systems' thinking and behaviour.

Although these five issues emerged as "common themes", there was no real agreement on preferred strategies for responding to any of them.

## The Public (Consumer) Environment

**A. Public perceptions of the health system**

There is broad public support for a health system that offers universal access and high quality care across a range of health services. At the same time, however, the majority of Ontarians understand that the current pressures on the traditional health system are more than fiscal and that reform is needed.

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The seven priorities (and action strategies) required to achieve greater 'systemization' of the provincial health system are outlined in Figure XII-2.

**Figure XII-2: A seven-point action plan for system-building**

**SEVEN-POINT ACTION PLAN**

**ACTION 1: Build on the implementation of hospital restructuring and reinvestment in other health facilities and community services.**

**ACTION 2: Articulate and communicate a vision of the future health services system in Ontario.**

**ACTION 3: Clarify and define the role of government as primarily responsible for system governance and leadership.**

**ACTION 4: Develop a comprehensive health information management system.**

**ACTION 5: Implement a new model providing comprehensive primary health care.**

**ACTION 6: Foster and support greater integration and co-ordination within and across the system by:**

- **Building on community efforts to strengthen integration**
- **Strengthening academic health science centres/networks**

**ACTION 7: Develop and implement a process for improving health system accountability and performance.**

## ACTION 1:
### BUILD ON THE IMPLEMENTATION OF HOSPITAL RESTRUCTURING INCLUDING REINVESTMENT IN OTHER HEALTH FACILITIES AND COMMUNITY SERVICES.

Action Strategies

☑ Identify a body (i.e., a physical presence/force within the MOHLTC or arms-length from the government) to:

- Implement HSRC directives in the various communities, and
- Act on the recommendations for reinvestments in non-acute care required in the various communities.

## ACTION 2:
### ARTICULATE AND COMMUNICATE A VISION OF THE FUTURE HEALTH SERVICES SYSTEM IN ONTARIO.

Action Strategies

☑ Articulate and communicate a vision (as well as mission and goals) for the health system to guide future reforms and service improvements. The government should use the following vision statement, developed by the HSRC, as a starting point to engage the public in a discussion of the strategic priorities and directions that will shape future health system change in the province:

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*Our vision is of a sustainable health system that provides compassionate, comprehensive, high quality care to everyone who needs help to regain and maintain good health. While reflecting community and regional differences, the system's health care providers work together toward the common purpose of meeting the publicly set goals, objectives, policies and priorities necessary to achieve Ontario's vision of health.* [80]

☑ Articulate and communicate the strategic priorities and directions for future health reforms that will achieve improved health status and contribute to building a health services *system*. The identification of priorities should be evaluated against three broad criteria, including:

- *Potential for improving quality, access and affordability of the 'system'*
- *Potential for improving integration, co-ordination and continuity of care in the 'system'*
- *Impact on re-balancing the elements of the 'system'*

### Discussion

The first requirement of any 'system' is that the several parts of which it is made have to march to the beat of a single drum. In ordinary parlance, that drumbeat is the vision of the organization. In the absence of a common vision and subsequently the corresponding statements of mission, goals, objectives and so on, a true health services system cannot exist.

Like many governing bodies, governments have, over the years, put entirely too much of their efforts into trying to *manage* or *operate* individual elements within the 'system' and altogether too little in creating a *genuine* system and providing it with the overarching governance that it lacks and badly needs. Much of this has to do with the fact that the stream of interest groups that have lobbied Queen's Park have consumed so much of the Government's time, reducing the role of government to one of arbitrator among interests. In this role, the government has dealt with competing and conflicting demands, rather than providing the *leadership* through which a shared vision of what is in the public interest can be developed and achieved. Developing and achieving a *shared vision* means ensuring alignment among –

- the vision of the system and its goals, objectives and strategic directions
- the goals, objectives, and strategic directions of the system and the design and limits of the funding systems
- the demands and needs of various sectors/players within the system
- appropriate incentives and corresponding actions that will encourage achievement of system-wide goals and objectives among all sectors/players in the system.

## ACTION 3:
## CLARIFY AND DEFINE THE ROLE OF GOVERNMENT AS PRIMARILY RESPONSIBLE FOR SYSTEM GOVERNANCE AND LEADERSHIP.

### Action Strategies

☑ The Government of Ontario (in addition to being the principal 'funder') should assume as its key area of responsibility the task of establishing itself as the *governing body* of Ontario's health

[80] The following Vision of Health was developed by the Ontario Premier's Council on Health Strategy and endorsed by all parties of the Provincial Legislature in the Spring of 1989: *We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work, and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender, or cultural background. Finally, we see everyone working together to achieve better health for all.*

services system – its Board of Directors – and discharging the responsibilities of governance through the MOHLTC.

☑ Redefine and clarify the role of the MOHLTC as the governors and leader of the health system, not as it is now, a centralized entity focused largely on operational matters ("micro-management"). In this role the MOHLTC would be responsible primarily for:

- Establishing the vision for the future health system and providing overall direction through legislation, regulations, policy guidelines, and standards;

- Funding and determining the appropriate funding levels within which the health services system operates;

- Ensuring development and maintenance of a shared, comprehensive health information system to link all elements of the system together;

- Inventing and promoting 'system redesign tools' (incentives/disincentives, performance targets, evaluation measures, etc.), strategies to achieve the vision of the future health services system and the values by which it should operate; and

- Accountability for follow-up on assessment/evaluation for improving the performance of the system overall with a view to ensuring that —
  - the people of Ontario get their money's worth,
  - the system continues to evolve to meet changing needs, and
  - standards of quality of service, accessibility and efficiency are maintained.

## Discussion

Fifteen years ago, all three political parties in Ontario endorsed a report by a Task Force led by Dr. John Evans – *The Evans' Panel Report* (1986) which summarized the themes of a number of previous health system reform reports that had been published prior to that time. Those themes were that the health system should be changed by:

- placing greater emphasis on primary care
- linking primary and secondary care
- achieving a community focus to care
- shifting resources from institutional to community care
- focusing on health promotion and disease prevention
- achieving co-ordinated planning
- co-ordinating services and eliminating service fragmentation, and
- funding for outcomes.

While a great deal of time and money has been spent by the governments formed by all three political parties (in turn) in Ontario to achieve these goals, very little progress has actually ever been made to change how the health care system is funded, managed and governed. In fact, one of the most serious, over-arching, and long-standing problems affecting the health services system now is that it does not have effective governance. Effective governance is critical to fostering *system-building* and *system change*.

As noted several times throughout this report, the HSRC discovered first hand that resistance to change from the public, health care providers, and the bureaucracy have all contributed impediments to implementation of effective change. In fact, resistance to change within the pubic service itself (the bureaucracy) has been one of the strongest forces slowing down and even arresting the pace of change in a number of areas (i.e., mental health reform).

This may well explain why Ministers (of all political persuasions) each of whom have articulated the same set of general goals and objectives have been unable to achieve "real" change. It may also explain why government ministries (including the MOHLTC) over the last many years have been so preoccupied with attempts to *manage* health care services in Ontario to the serious neglect of *governance* — the leadership vacuum — of the health care/services system.

It is the Commission's perception that the bureaucracy fears 'downsizing' and loss of power if managing were to be devolved to those "on the ground" and *governing/leading* health services were to become the Ministry's (and government's) primary focus. Governance of the 'health system' implies that the system, and all of its parts, must:

- March to the drum of a common vision and a clearly defined mission
- Operate within clear policy guidelines
- Strive for achievable, measurable goals and objectives, and
- Receive the benefit of evaluative 'feedback' — all products of good governance.

The commitment to share publicly the financial risks of disease and injury is, to all intents and purposes, a defining characteristic of being Canadian. Discussions about health services and the health system generally refer to *public* services within that system. There is no doubt that most Ontarians continue to be committed to a public health services system. Therefore, the reality is that that governance of health services must be provided by governments, by the elected representatives of the people affected.

Clarifying the role of government as the senior governor of the system will require shifting a great deal more of the responsibility for *managing* health services to accountable organizations located close to and controlled by the people and communities who receive health services and those who provide them.

Just as Parliament devolves work and power to the government and its Ministries/Departments, the HSRC believes it essential that the MOHLTC do two things:

1. Take up the vital responsibility of providing effective governance to the health services system, and

2. Shift responsibility for management of the system and the operation of its elements to bodies made up of local representatives of users and providers of health services.

There is little agreement on what these management structures should look like. how much authority should be devolved to them, and who should be part of them. Is the 'optimal' structure a Regional Health Authority (like those established in most other provinces across Canada), IHS, or is it some other local authority or special purpose body?

What might, in fact, be more important than defining the 'right' or 'optimal' structure is determining whether or not, and how, the following principles are respected:

1. Effective management should be built on stronger partnerships and linkages between and among the many providers, organizations and sectors within the health services system.

2. Management should be located within regions or geographic sub-divisions throughout the province, the definition of which is generally agreed (with the exception of the conurbation referred to as the Greater Toronto Area in which non-geographic divisions would be more appropriate).

This last point, in particular, was an issue explored more fully by the Commission in its work on improving health systems performance.

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# ACTION 4:
## DEVELOP A COMPREHENSIVE HEALTH INFORMATION MANAGEMENT SYSTEM.

> ***Health information management:***
> **The capture, sharing and analyzing of information to make better decisions.**

### Action Strategies

Implement the HRSC's strategy — *Ontario's Health Information Management Action Plan* — to develop a comprehensive health information management system (IM) in Ontario to improve integration and co-ordination of health services delivery and to improve overall health system performance.[91] The following steps should be undertaken to begin implementation of the plan:

1. Enact personal health information legislation and regulations.
2. Establish a Health Information Management Agency as an arms-length entity, accountable to the government, and reporting to the Minister of Health.
3. Establish an interim Advisory Council to act as transition leadership while the Agency is being established.
4. Allocate the necessary funding to be distributed by the Health Information Management Agency.
5. Ask the interim Advisory Council to develop detailed implementation plans for launching each initiative (including design details, timing, responsibilities, performance measures) and develop required processes for effectively conducting its roles on standards, privacy, funding, strategy, advice, and audit.

### Discussion

Currently, Ontario's health system lacks the needed information and information exchange to achieve the desired co-ordination and integration. Health providers would be more successful in co-ordinating services if they had the tools to exchange information on a timely basis. In addition, many health sectors — especially community and long-term care — have not integrated computer and information tools into their daily operations, further restricting the potential for real co-ordinated care delivery.

In early 1999, the HSRC established an Information Management (IM) Working Group, chaired by Dr. Michael Guerriere of the University Health Network to address these concerns. The Working Group included a number of senior health care leaders from Ontario and Canada. The Working Group was asked to help the HSRC formulate a strategy to develop a provincial health IM system that would improve the integration and co-ordination of health services delivery and overall health system performance. The group met over a four-month period (assisted by McKinsey & Company); it drew on the recommendations of many reports over the past several years, including *Ontario's Smart System for Health*, the Canadian Institute for Health Information's *Health Information Roadmap*, and Health Canada's *Health Infoway*.

In June 1999, the HSRC submitted the report — *Ontario's Health Information Management Action Plan*, which included a series of recommendations, to the Minister of Health. The strategy outlined the ways and means to create a capacity in Ontario to manage information relating to health and the provision of

[91] A total of 22 health IM initiatives are included in the three-year action plan to address: **Improving consumer information** (initiatives include creating a consumer information hotline and a consumer web site to provide advice and answer questions on health and health services); **Improving health services delivery at the point of care** (initiatives include developing a province-wide drug and lab information program to make available to designated providers, prescription and lab result histories for consumers); **Improving health services management** (initiatives include improving needs forecasting such as, professional health resource needs and expanding analytic capacity to measure a broader scope of health services practices).

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health care services. As part of its final advice, the HSRC advised the Minister that developing the capacity to collect, analyze and distribute information to providers and consumers alike relating to the continuum of care is the number one priority for improving the health system. Health information and effective management constitute the *fundamental enabler* of all other health reforms and system-building. In the absence of data and information leading to knowledge there can be no effective accountability either for governance or operation of health care services.

Health care providers are unable to provide co-ordinated care to consumers, in part, because there is insufficient communication across the care continuum about consumers' needs and the health care services required to meet them. Health care providers want to improve co-ordination of care, improve timely access to needed services and ensure the best use of resources. The real-time capture and exchange of patient-oriented health information is a key requirement to achieve these objectives.

In addition, consumers want more information on their health and how to access the health system. They should be provided access to communication channels that meet their needs and help them navigate the health system.

While organizations and providers across the entire health system are investing in technology and software to support their operations, there is no guiding framework to co-ordinate that work or facilitate the sharing of information now, or in the future. Presently, very little health information can be shared because of the lack of common standards and limited use of common identifiers. Another very significant factor is the absence of a comprehensive legislative framework to protect the privacy of health information. The longer this continues, the more difficult it will be to remedy.

As the HSRC's mandate comes to a close, it remains committed to the urgency and importance of developing a new health information management strategy for Ontario's health system. The Commission recognizes the size and complexity of the task and the significant investment that is required. There is, however, no question that developing a health information management system is the top priority for building a better health system. It promises to deliver the most return to consumers, providers, managers and government. Without health information management, neither reform nor system-building will be possible.

## ACTION 5:
### IMPLEMENT A NEW MODEL PROVIDING COMPREHENSIVE PRIMARY HEALTH CARE.

> ***Primary health care:*** The first point of contact Ontarians have with the health care system. It is the foundation of a genuinely integrated system of health care services, and an essential component for improving continuity of care.

**Action Strategies**

☑ Implement the HSRC's *Primary Health Care Strategy* (December 1999) provincially, in a planned and comprehensive manner, over the next six years.

☑ Establish an Implementation and Monitoring Committee made up of external representatives of consumers, health care professionals and managers to implement the strategy. Support the committee with a secretariat and have it report directly to the Minister of Health.

☑ Identify a champion with sufficient authority to affect change, to be responsible for leading the transition in primary health care, and to ensure primary health care receives a high priority in government and the full support of consumer and provider groups.

## Discussion

Primary health care activities in Ontario are both extensive and resource intensive. Greater demands are being placed on primary health care as a result of factors such as the aging population, the increased prevalence of chronic diseases, consumer empowerment and hospital restructuring.

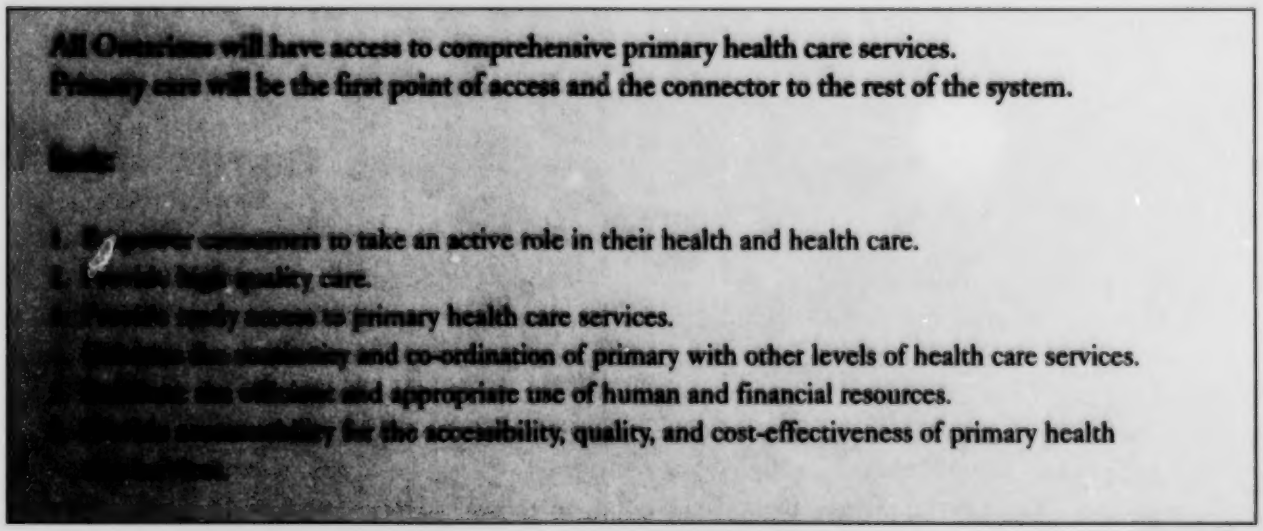
For decades, primary health care has been the subject of much study and debate in Ontario. Many studies have made similar recommendations and have come to similar conclusions. *There is strong agreement that a co-ordinated system of primary health care must be developed and integrated with other levels of health care including community-based and specialty services.* Despite this agreement on the need for change and the components necessary to support it, there has been little substantive progress on improving primary health care services in Ontario.

The primary health care strategy developed by the HSRC is not novel. Most of its characteristics are common to other primary care models previously proposed. The HSRC's approach to primary health care is to:

- Put Ontarians at the centre, where they will play an active role in their health care.
- Build on the strengths and positive attributes of current primary care models.
- Identify the key conditions needed to support change (e.g., education of health professionals).
- Develop a strategy to implement primary care provincially, in a planned and comprehensive manner over the next six years.

In December 1999, the HSRC released its report, *Primary Health Care Strategy*. The strategy included a vision and goals for primary health care (see Figure XII-3) and identified five essential features and five supporting mechanisms in addition to critical success factors for implementation of the strategy. In total, 29 recommendations were made on the development of a primary health care system.

**Figure XII-3: The vision and goals of primary health care**


All Ontarians will have access to comprehensive primary health care services.
Primary care will be the first point of access and the connector to the rest of the system.
Goals:
1. Empower consumers to take an active role in their health and health care.
2. Provide high quality care.
3. Provide timely access to primary health care services.
4. Improve the continuity and co-ordination of primary with other levels of health care services.
5. Promote the efficient and appropriate use of human and financial resources.
6. Provide accountability for the accessibility, quality, and cost-effectiveness of primary health care services.

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**All Ontarians will have access to comprehensive primary health care services.**
**Primary care will be the first point of access and the connector to the rest of the system.**

**Goals:**

1. **Empower consumers to take an active role in their health and health care.**
2. **Provide high quality care.**
3. **Provide ready access to primary health care services.**
4. **Enhance the continuity and co-ordination of primary with other levels of health care services.**
5. **Facilitate the efficient and appropriate use of human and financial resources.**
6. **Provide accountability for the accessibility, quality, and cost-effectiveness of primary health care services.**

**The five essential features** of the primary health care strategy are:

- ***Access to a defined range of comprehensive primary health care services.***

- ***Services accessible 24-hours-a-day, 7-days-a-week,*** with telephone triage being an important enabler of this comprehensive coverage.

- ***Health care professionals working in group practices,*** and providing comprehensive primary health care to a defined population. Groups will include physicians and nurse practitioners together with other health care professionals directly involved in the delivery of care in the group practice.

- ***Consumers enrolling with the primary care physician or primary care nurse practitioner of their choice,*** each of whom is a member of the same group.

- ***Primary health care groups organized as groups of inter-professional primary care providers*** who share common goals, contribute in a co-ordinated manner according to their competencies and skills, and respect the functions and distinctive contributions of others. Primary care physicians and primary care nurse practitioners will form the core team of each group, with other clinical and administrative support functions added to meet the care needs of the enrolled population for comprehensive primary care.

**The five supporting mechanisms** to ensure the success of primary care groups are:

- ***Population-based group funding*** with funding flowing directly to the group which will then determine the method(s) of remuneration for all providers within the group. Funding will include: 1) population-based funding (capitation) to pay for the core basket of primary health care services; 2) funding for programs that go beyond the core basket of services to address the specific needs of a defined community or consumers that are difficult to enroll; 3) sessional payments to the group for other services such as emergency work, surgical assists, telemedicine consults and visits to homes, hospitals and long-term care facilities; and 4) a quality incentive system when agreed-upon targets are met in defined areas.

- ***Education*** to support the development of groups and help them to meet the needs of their enrolled consumers. The MOHLTC must invest stable and ongoing funding to support the education of nurse practitioners in Ontario. An education task force will identify education initiatives to support the strategy. The task force will develop strategies to increase training opportunities for nurse practitioners, support cross-training of midwifery and nursing, and support collaborative education opportunities among the health professions. The task group will also develop and recommend education programs on working effectively in groups of inter-professional providers, enhancing skills of health care providers, and strategies on how groups can educate enrolled consumers on maintaining health.

- ***Information management*** to support the real-time capture of consumer-oriented health information and the secure exchange of relevant and accurate information as appropriate in the delivery of care. Groups should have electronic access to drug and laboratory information, and local CCACs and DHCs should develop directories of community resources to enable groups to arrange the best services for their enrolled populations.

- ***Mechanisms to co-ordinate care*** that include: 1) an individual health record (each group compiles and is the custodian of a health record for each consumer, who owns his/her information and determines who has access to it; 2) agreements

between primary health care groups and other organizations and health care providers who offer different levels of care; and 3) communication protocols and care paths with special attention to hand-off points when consumers are transferring from one level of care to another.

- ***Mechanisms to ensure accountability*** that include mutual accountability between groups and their enrolled members, accountability of groups to the MOHLTC, accountability of groups for governing and managing their operations; and accountability for quality improvements.

The primary health care strategy proposed three possible primary care group models. The number of primary care physicians and nurse practitioners comprising the core team differed in each of the three models, with the core team ranging from four to eight providers as follows:

| Primary Care Model | Geographic Population | Core Team | Enrolled population |
|---|---|---|---|
| Urban | >15,000 | 6 physicians, 2 nurse practitioners | 1,874 enrolled consumers per MD or NP |
| Rural | at least 5,000[82] | 2 physicians, 2 nurse practitioners | 1,331 enrolled consumers per MD or NP |
| Remote | all other situations | 1 physician, 3 nurse practitioners | 1,178 enrolled consumers per MD or NP |

A proposed implementation plan developed by the HSRC sets out the activities to achieve the strategy and the organizations responsible for these activities. Year one of the plan includes:

- communicating support for the strategy;
- putting a structure in place to support implementation activities; and
- doing the groundwork for moving ahead.

In years two to six, groups are developed throughout the province in a planned fashion.

While the vast majority of the HSRC's primary health care strategy is common to previously proposed primary care models it does include a number of 'unique' features:

- **An enhanced role for nursing.** Primary health care is provided by primary care physicians and nurse practitioners working in partnership, not as substitutes, but each applying their particular professional skills and approaches. This core team is enhanced by other health professionals. This multi-professional approach makes more effective use of the skills of all involved health professionals (especially of nurses), improves access to primary health care services, and reduces reliance on emergency departments.

- **True group practices with supporting administrative structures.** This feature enhances professional peer support and leads to improved quality of care and system efficiencies.

- **Improved conditions for primary care physicians** including an attractive, predictable compensation package, a quality incentive system for meeting established goals, and assistance with support and capital services (the overheads of practice).

[82] PCG in one physical location and can be reached within an hour.

These incentives are designed to facilitate members of group practices locating in the same physical setting.

- **Funding flows to the group based on the enrolled population served.** While continuing to honor the individual nature of the physician/patient and nurse practitioner/patient relationship, this highlights the group's responsibility for the health and health care of its enrolled population. It encourages and permits the selection of payment mechanisms most suitable to the members of each primary health care group.

- **Comprehensive provincial implementation of the strategy.** Progress must and can be made more quickly if primary health care is to meet the changing needs of Ontario's population and contribute to the development of a genuinely integrated health care system.

## ACTION 6:
## FOSTER AND SUPPORT GREATER INTEGRATION AND CO-ORDINATION WITHIN AND ACROSS THE SYSTEM BY:

### A: BUILDING ON COMMUNITY EFFORTS TO STRENGTHEN INTEGRATION

#### Action Strategies

☑ Identify a champion within the MOHLTC who is responsible for health system integration.

☑ Establish an annual competitive grant program that awards seed money to communities that are initiating local integration initiatives.

#### Discussion

Ontario has an extensive range of dedicated health care organizations and providers who function quite independently of each other. Various arrangements exist to link groups of organizations and providers into networks or alliances, but the true interdependency and interaction that characterizes a well-functioning health services system does not exist.

Much of the HSRC's work has focused on advancing integration and co-ordinated services. These include hospital restructuring, the advice and recommendations on rural and northern hospital networks, the health information management strategy, and the primary health care strategy. These activities have helped to create a stable foundation for integration using *multiple footings*. The Commission concluded, however, that advancing community integration was an additional footing needed in the foundation. Bottom-up grassroots level approaches to integration are actively being led by communities. Identifying and encouraging these initiatives provided concrete practical evidence of what is required for successful integration at the community level.

The HSRC supported vertical integration projects in several communities and explored existing innovative integration initiatives in Ontario. Case studies and lessons learned were documented in the HSRC's report, *Advancing Community Integration: Experiences and Next Steps.*

#### Supporting Vertical Integration Projects in Local Communities

The figure below summarizes the communities and key projects included as part of this initiative.

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**Figure XII-4: Community integration projects**

| COMMUNITY / PARTNERS | PROJECT |
|---|---|
| **Durham**<br>• Durham Access to Care<br>• Lakeridge Health Care Corporation<br>• Durham Region Health Care Group | **Integration of Palliative Care Services in Durham Region**<br>To work within Durham Region to:<br>• Develop a process for the integration of palliative care services at the community level; and<br>• Identify gaps in the provision of essential palliative care services and strategies to address these gaps. |
| **Kingston**<br>• Health Care Network of Southeastern Ontario | **Integration in the Diagnosis and Care of Early Stage Prostate and Breast Cancer in Southeastern Ontario**<br>Examine current activities and identify improvements in:<br>• Relationships and co-ordinating mechanisms among service providers including those working in preventive care, primary care and supportive care;<br>• Information (a real-time regional cancer database and registry); and<br>• Mechanisms for timely and co-ordinated regional decision-making. |
| **London**<br>• The Thames Valley DHC<br>• Essex Kent and Lambton DHC<br>• Grey Bruce Huron Perth DHC<br>• Joint Executive Committee (London hospitals) | **Integration Through the Development of a Diabetes Care and Education Network in Southwest Ontario**<br>To work within Thames Valley and Southwest Ontario to:<br>• Identify district co-ordinating centres, community diabetes care and education centres and practice algorithms; and<br>• Pilot a diabetes electronic medical system as a medical record, a data collection tool and as a basis to establish a patient registry. |
| **Sault Ste. Marie**<br>• Working Group made up of Plummer Memorial and General Hospital, Group Health Centre, Algoma District Medical Group, Community Care Access Centre | **Exploring Integrated Health Services in Sault Ste. Marie**<br>To explore an integrated health system by conducting background work, developing strategies, identifying funding sources, clarifying roles and responsibilities, and recommending a model of integrated health services in Sault Ste. Marie. |
| **Timmins**<br>• Timmins and District Hospital<br>• Public health<br>• Three school boards<br>• Children's Mental Health Agency | **Developing an Integrated Approach for Children with Learning and Behavioral Problems in Timmins**<br>• Developing a community-wide evidence-based practice guideline for children with potential learning and behavior problems;<br>• Developing strategies for community education to increase awareness; and<br>• Developing assessment skills to recognize problems and refer to appropriate treatment. |

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| **Toronto**<br>• Toronto District Health Council with the following health service networks in Toronto:<br>1) Partners for Health;<br>2) The Community Health Network of West Toronto;<br>3) South East Toronto Project;<br>4) Community Health Assessment and Improvement Network;<br>5) West End Health Alliance;<br>6) West End Urban Health Alliance; and<br>7) Scarborough Growing Healthy Together Coalition. | **Documenting the Integration Experiences of Toronto Networks**<br>To document the integration experiences of seven well-established health networks in Toronto to:<br>• Examine their histories and structures; and<br>• Identify barriers to and opportunities for integration, success factors and lessons learned for integration. |

In addition, three innovative integration initiatives were examined to further understanding and knowledge about integration:

- Co-ordinated Stroke Strategy (Heart and Stroke Foundation)
- Northeast Ontario Integration Task Force (Mental Health)
- Algonquin Health Services

## Factors that Support Successful Community Integration

The HSRC's integration initiatives provided valuable insights into the factors that lead to and sustain successful community integration. Five factors are discussed:

- *What brings organizations to the table and keeps them there?*
- *Who's at the table?*
- *What do organizations bring to the table?*
- *What structures are needed? and,*
- *How are realistic expectations maintained?*

### *What brings organizations to the table and keeps them there?*

- **A catalyst for change.** There must be a reason for organizations to come together to discuss changing how they do business. The HSRC was a catalyst for integration efforts in the community integration projects simply because it conducted some preliminary work with communities and provided modest funding to help kick-start integration initiatives.

- **An agreed-upon approach to integration.** There are different approaches to integration, each of which has a different focus and advances integration at different levels. The approach that is selected determines the objectives that are set, the strategies and effort that are needed to move integration ahead, and the barriers that must be overcome. Micro- and macro-level approaches were evident in the different community projects. As well, two types of integration activities were evident: programmatic and structural.

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| COMMUNITY / PARTNERS | PROJECT |
|---|---|
| • Toronto District Health Council with the following health service networks in Toronto:<br>1) Partners for Health;<br>2) The Community Health Network of West Toronto;<br>3) South East Toronto Project;<br>4) Community Health Assessment and Improvement Network;<br>5) West End Health Alliance;<br>6) West End Urban Health Alliance; and<br>7) Scarborough Growing Healthy Together Coalition. | **Documenting the Integration Experiences of Toronto Networks**<br>To document the integration experiences of seven well-established health networks in Toronto to:<br>• Examine their histories and structures; and<br>• Identify barriers to and opportunities for integration, success factors and lessons learned for integration. |

In addition, three innovative integration initiatives were examined to further understanding and knowledge about integration:

- Co-ordinated Stroke Strategy (Heart and Stroke Foundation)
- Northeast Ontario Integration Task Force (Mental Health)
- Algonquin Health Services

## Factors that Support Successful Community Integration

The HSRC's integration initiatives provided valuable insights into the factors that lead to and sustain successful community integration. Five factors are discussed:

- *What brings organizations to the table and keeps them there?*
- *Who's at the table?*
- *What do organizations bring to the table?*
- *What structures are needed? and,*
- *How are realistic expectations maintained?*

### *What brings organizations to the table and keeps them there?*

- **A catalyst for change.** There must be a reason for organizations to come together to discuss changing how they do business. The HSRC was a catalyst for integration efforts in the community integration projects simply because it conducted some preliminary work with communities and provided modest funding to help kick-start integration initiatives.

- **An agreed-upon approach to integration.** There are different approaches to integration, each of which has a different focus and advances integration at different levels. The approach that is selected determines the objectives that are set, the strategies and effort that are needed to move integration ahead, and the barriers that must be overcome. Micro- and macro-level approaches were evident in the different community projects. As well, two types of integration activities were evident: programmatic and structural.

*Programmatic integration* — a micro-level approach — brought together organizations that provided different types and levels of care to people with a common clinical condition. *Structural integration* — a macro-level approach — focused on the level of the organization. Typically discussions centred around shared or joint governance and management arrangements that would improve efficiencies, promote integrated services, and enhance quality of care.

- **A common purpose and goals.** Successful integration projects had a common sense of purpose and agreed-upon goals.

- **Agreed-upon activities to meet the goals.** Integration initiatives that were successful had a clear plan of action that included agreed-upon activities, priorities for action, deliverables and deadlines. These pieces were fundamental to translating integration from a visionary concept into reality.

- **Readiness and willingness to pursue integration.** Health care organizations and institutions within each community were at various stages of willingness and readiness to embark on vertical integration activities.

*Who's at the table?*

- **A champion or leader.** A champion or leader was essential to help direct the integration initiative and ensure that the activities were completed. The probability of having a successful integration project increased if the champion dedicated a block of time to ensure that the work got done.

- **The appropriate mix of participants.** Successful integration included the participation of a wide range of providers. Not all providers necessarily needed to be involved in each aspect of the integration initiative. Typically the broader the membership was, the more work was needed to set the common goal, priorities and agreed-upon activities. Participation in integration initiatives worked best when there was a certain degree of fluidity to the membership.

- **Willingness to conduct integration activities as partners.** Successful integration is based on the premise that participants are equal players with a common objective. In many of the community projects, there was perceived inequity between institution- and community-based service providers. Communities that recognized and dealt with these perceptions were more successful in advancing integration.

*What do organizations bring to the table?*

- **Human and financial resources.** Integration activities require resources – either time, staff or funding – resources that were usually over and above the resources available and needed for the work of individual organizations. Many integration initiatives were successful due to the in-kind contributions made by organizations through the expertise and time of their staff.

- **Appropriate attitudes and motivations.** Voluntary approaches to furthering integration had to be built on a foundation of trust and respect among the partners. Reluctance to develop partnerships and a shared vision was often based on the fear of hidden agendas, behaviors and actions that speak of self interest rather than the best interests of the health care consumer — the beneficiaries rather than the providers of care.

***What structures are needed?***

- **Effective, appropriate and flexible structures.** In a number of the community integration projects, working relationships and formal structures had to be developed between organizations that had not routinely worked together in the past. A balance had to be achieved between structures that needed to be formal enough to bring a necessary discipline to bear on the task at hand, and flexible enough so that progress was not hindered.

***How are realistic expectations maintained?***

- **Appropriate time and energy commitment.** Deciding on the specific integration activity to undertake took time to negotiate, usually between parties with competing interests and different perspectives. It also took time to develop working relationships between organizations that had not routinely worked together in the past, or that had not established formal structures on how to approach integration opportunities.

- **Achievable goals.** Setting achievable goals for integration was determined largely by the amount of time, energy and resources that organizations were prepared to offer and put into the process. Ambitious goals that went beyond the readiness and willingness of the partners, did not succeed.

- **Recognizing the limitations of government support.** It was widely believed that government's willingness and readiness to support vertical integration initiatives influences the success or failure of new initiatives. Communities that were most successful recognized the limitations of government support, and did not use these limitations as an excuse to avoid embarking on local integration initiatives.

Based on the HSRC's experience with the integration projects, it is clear that communities can achieve a great deal of local integration at a micro-level. However, these efforts can be significantly enhanced by:

- Identifying a champion within the MOHLTC who is responsible for integration and whom communities can contact; and
- Establishing an annual competitive grant program that awards seed money to communities that propose and are initiating local integration initiatives.

## B: STRENGTHENING ACADEMIC HEALTH SCIENCE CENTRES/NETWORKS

**Action Strategies**

☑ Ontario's Academic Health Science Centres/ Networks are vital to the creation of a stronger, more integrated health services system. It is past time, and very much in the interest of the people of Ontario, that the MOHLTC establish the mechanisms necessary to work with them to achieve their full potential.

☑ Act on the recommendations of the Provincial Co-ordinating Committee on Community and Academic Health Science Relations (PCCCAR) in its reports: [83]

- *Sustaining Ventures for Their Communities (1995)*, and
- *Funding Academic Heath Science Networks: An Investment in the Future (1997).*

[83] Provincial Co-ordinating Committee on Community and Academic Health Science Relations (PCCCAR): *Ontario's Academic Health Science Centres: Sustaining Ventures of Their Communities (1995) and Funding Academic Heath Science Networks: An Investment in the Future* (1997).

These reports made a number of recommendations that have yet to be implemented to address health human resources planning, funding mechanisms for AHSCs and implementation approaches that should be followed to make more effective the roles and responsibilities of AHSCs throughout Ontario.

## Discussion

There are five AHSCs in Ontario located in those cities that have universities with Faculties of Medicine/Health Sciences: Kingston, Hamilton, London, Ottawa, and Toronto. AHSCs have long been recognized for discharging three prime responsibilities:

- the education of future physicians and other health professionals
- the conduct of health research (basic, clinical and health services) and development, and
- the provision of highly specialized, sophisticated (tertiary and quaternary) clinical services.

They are, however, less recognized for meeting a fourth responsibility that is consistent with their nature as "partnerships of institutions" — primarily hospitals and universities, with both academic and clinical service missions. That responsibility is leadership in change. This includes anticipating and meeting the challenges of changing times and needs and leading others in the change process as well.

As the HSRC considered ways and means of improving co-ordination and integration in our health system, it explored the potential role for AHSCs. In particular, the Commission wanted to find out whether and how Ontario's five centres could lead the way in forming new organizational relationships to create, within their regions, the conditions for improved quality and access through greater co-ordination and integration.

In January 2000, the HSRC hosted a workshop involving participants from each of the five AHSCs in Ontario, the MOHLTC, community hospitals and a number of community organizations. The HSRC's deliberations were informed by the issues raised in the workshop as well as the work it undertook during Phase 1 of its mandate in each of the five communities that included an AHSC.

Although the HSRC was unable to complete an in-depth study before the end of its mandate, some of the initial (preliminary) perspectives and observations made about the future role of these centres in leading integration were:

- **AHSCs need the mandate and resources necessary to transform themselves into true networks.** This is particularly true for those centres outside Toronto where regional *Academic Health Science Networks* (AHSNs)[84] must extend over large areas of the province

- **AHSCs have the assets and capabilities to lead the way, and could do so with a broadened mandate and expectation for a broader role in leading system change.** AHSCs have an important role in system-building and in developing organizational relationships that lead to improved co-ordination and

[84] There has been much written on academic health science networks (AHSNs) as the vision for the future of academic health science centres. The 1995 PCCCAR Report — *Ontario's Health Science Centres: Sustaining Ventures for Their Communities* — discussed the development of AHSNs as networks that: develop working partnerships based on a common goal(s), with a shared sense of leadership rather than centralized or hierarchical relationships; adopt a needs-based approach rather than being supply side driven; allow the institutions that are now part of the AHSCs (as well as those that would become part of the network) to work together and make the most effective use of available skills, knowledge and resources for patient care, research and education; are comprised of a set of inter-relationships among (but not limited to) organizations including teaching hospitals, community hospitals, health units, long-term care institutions, community care providers/ organizations, district health councils and other health planners, private-sector/health-related researchers and businesses, health science professional faculties, colleges of applied arts and technology that educate health professionals and secondary schools.

integration of patient care. The current environment is driving AHSCs to broaden their reach to ensure success in the academic missions of research, education and patient care. This broadening of their roles would be facilitated greatly were these centres to be given formal responsibility and resources necessary to convert themselves from centres into *networks*.

- **There are a variety of barriers and disincentives that must be addressed in advancing the concept of an Academic Health Science Network.** Networks have not developed as quickly as proposed for a variety of reasons, some of which vary from one centre to another. Over the last several years, most communities have been preoccupied with reform and restructuring. Existing funding systems are poorly co-ordinated and allow almost no flexibility to move funding from one component of the "system" to another. There is also a great deal of fear and discomfort with what is perceived as being the "overwhelming task" of bringing a broad range of organizations and providers together to address needed system changes.

- **The universities and teaching hospitals that today constitute Ontario's AHSCs represent a substantial investment; however, their potential remains only partially realized.** This is attributable largely to an overall lack of mandate setting out the government's expectations of these centres/networks in carrying out system-wide goals and objectives. They also lack the tools necessary to achieve those goals. For example, they need a strengthened mandate that will allow them to play a key role in creating the capacity in Ontario for sensible long-range planning that will ensure sufficiency in health human resources and subsequently implementation of those plans.

## ACTION 7:
## DEVELOP AND IMPLEMENT A PROCESS FOR IMPROVING HEALTH SYSTEM ACCOUNTABILITY AND PERFORMANCE.

### Action Strategies

☑ Assess the relationships among the components of the system and the extent to which there is improved co-ordination of services and better continuity of care.

*Improving health system performance must take an integrated system perspective that recognizes the importance of the individual parts of the service continuum, but more so, the interdependencies and relationships between and among these parts. Although assessments of individual organizations are important, these evaluation initiatives cannot simply be combined to determine where health system performance can be improved. Indeed, the whole is (or should be) greater than the sum of its parts.*

☑ Establish a **Health System Improvement Council** with the goal of ensuring, monitoring, assessing and improving the performance of the health system in Ontario.

*Providers in the service continuum should be responsible for improving the performance of their members. However, system improvement should not be the responsibility of any one or a select group of providers. No single provider group, organization or institution has the overarching perspective that is required to support ongoing comprehensive improvement of the health services system.*

### Discussion

A rigorous and comprehensive approach to improving accountability and performance is critical for a dynamic health care system that responds to the needs of consumers and continuously strives for

improvement. A health services system that has the capacity to improve its performance continually, will result in better health services delivery and improved health of the population.

Improving performance means doing things better and continually improving situations, relationships, programs and services. Improvement incorporates the notion of accountability — *that people, organizations, sectors, government and systems are accountable for ensuring that expectations are met, standards are adhered to, responsibilities are fulfilled, and changes are made for the better.* Indicators of performance should be easily accessible to help consumers make informed choices about such things as treatment options and choice(s) of provider.

In the spring of 1999, the HSRC began work on developing a focused strategy to improve the performance of the health services system in Ontario. The following conclusions were made:

- **Assessing health system performance assumes that there is a system to be assessed.** The notion of a system emphasizes connections, interactions and interdependencies. Ontario has an extensive range of dedicated and excellent health care organizations and providers who function quite independently of each other. Although various arrangements exist that link groups of health care organizations and providers into networks or alliances, the interdependency and interaction that characterizes a *system* do not exist in Ontario.

- **There are many health care assessment initiatives currently under way in Ontario and elsewhere.** While most of these recognize the multi-dimensional aspects and the complexities of assessing performance, they tend to focus on particular organizations, sectors or communities. Although these initiatives are valuable for assessing the performance of their respective sectors, the results have limited applicability in assessing the performance of the health system as a whole.

- **With few exceptions there is a lack of agreed-upon indicators, and objective standards, benchmarks and guidelines against which performance can be assessed.** Measures of performance, effective mechanisms for co-ordinating care and baseline service targets are currently not an intrinsic part of guiding decisions about, and making improvements in, the health services system. They should be.

- **Improving health system performance is hampered by methodological problems that include a lack of timely, valid and reliable data, data definitions and data collection protocols; and the use of *different* geographic boundaries by health care organizations involved in assessing performance.**

- **It is unclear who is accountable for improving health system performance. The result, of course, is that nobody is.**

## The HSRC's Approach to Developing a Strategy for Improving Health System Performance

The HSRC's approach to assessing health system performance has been to:

- Put the people of Ontario at the centre, recognizing their right to accessible, top quality and cost-effective health care;
- Support the important role of consumers in developing a top quality health care system that is responsive to their needs;
- Build on current activities and initiatives that assess the performance of organizations, sectors and communities; and
- Bring an overall system perspective to improving performance.

The HSRC's strategy for improving the performance of Ontario's health services system identifies the focus and key features for continuously improving performance, and clarifies who is responsible for improving system performance. Five key areas were addressed in the strategy:

1. **Focus on improving health *system* performance:** There are many health care assessment initiatives in Ontario and elsewhere. Generally, these recognize the multi-dimensional aspects of assessment, and the importance of a range of indicators and measures to assess performance. Initiatives that assess the performance of particular organizations, sectors or communities focus on individual pieces of the continuum of services. These initiatives serve an important purpose by encouraging improvement within sectors and organizations. These activities should continue and should remain the responsibility of each sector or organization. However, improving the performance of the health services system must take a *system* perspective rather than a perspective that focuses solely on individual providers, professional groups or organizations.

2. **Identifying key features of performance:** Improving health system performance must incorporate indicators that measure four system components: input, process, outcomes and feedback. Although it is important to incorporate indicators in all four categories, a common observation about current assessments is that they tend to address inputs, process and some outcomes, but fall short on feedback. Although effective health performance assessment addresses all of these areas, the feedback category provides crucial information on what does and does not work well, and identifies where improvements must be made. Obviously feedback that leads to improvements being made must be based on sound knowledge of outcomes. This too is deficient throughout most sectors.

Improving performance is a complex task that must make sense of a wide range of multi-dimensional factors of a quantitative and qualitative nature. The three essential criteria to assess health system performance improvements should be quality, accessibility and affordability. Selection of a small number of carefully chosen indicators based on useful, accurate and timely information, would be more useful for decision-makers than a large number of indicators. Indicators should assess the relationships and potential gaps between providers, the smooth and effective movement of people through the system, and the system's capacity to respond to demands for services.

The process of improving health system performance should *use a small but precise set of indicators* that can be tailored to the needs of decision-makers at different levels. Although the selection of indicators will be influenced by the availability of data, the development of additional data sources, where necessary, should be undertaken.

3. **Information, benchmarks and common regional boundaries:** There are methodological limitations to collecting health care data and improving performance. In addition, consistent geographic boundaries are not used by the various organizations that conduct assessments in Ontario. Since different organizations sub-divide the province differently, it is difficult to assess system performance regionally or locally. Therefore it is critical to select common regional boundaries to support health system improvement activities. Common boundaries will also support other system activities such as regional program and resource planning.

4. **Access to information:** The general public and health care consumers are increasingly expressing interest in health system performance. This increased interest has been fuelled to a certain extent by the media's dramatic reporting of the shortcomings of the health care system.

   Performance indicators that are selected should be meaningful, useful and dynamic. They should also help to identify critical problems, pressure points and track changes over time. Not only should systems seek to improve their future performance in relation to their past performance, but improvements should also be made in comparison with other jurisdictions (e.g., regional comparisons within Ontario, comparisons between Ontario and other jurisdictions). The impact of comparing performance over time and with others will lead to further improvement in the health services system.

   Assessing performance is fruitless unless the results feed back into making improvements. One of the most effective ways to ensure that system performance is improved, is to make results available to consumers, health care organizations, providers and others. Assessment results will encourage providers to improve their performance and influence consumers' behavior when seeking service. Ontario's consumers should be able to access performance information easily and routinely. Methods of communication can include annual reports, town hall meetings and internet access to web sites. Access to this information will empower consumers to make decisions about their health care, and to assess where system improvements need to be made.

5. **Responsibilities for health system improvement:** Although providers in the continuum should be responsible for improving the performance of their members, system improvement should not be the responsibility of any one or a select group of providers. These organizations do not have the perspective required to support ongoing comprehensive improvement of the health services system.

The responsibility for improving health system performance should rest with an independent, arms-length organization from the MOHLTC. The Health System Improvement Council should be made up of consumers, with providers acting as advisors. The goal of the Council should be to ensure, monitor, assess and improve the performance of the health system. The HSRC's document — *Strategy for Improving Health System Performance* (March 2000) includes proposed terms of reference for the Council.

# Section XIII:

## Lessons Learned: Looking Back and Looking Forward

Summary of Findings

Looking Back

Looking Forward: What Next?
Where to from Here?

HSRC Deliberations

HSRC

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# SECTION XIII: LESSONS LEARNED: LOOKING BACK AND LOOKING FORWARD

Other provinces in Canada have had experience in restructuring hospitals primarily through the creation of regional or district health bodies who have been delegated responsibility for making decisions about hospitals and, in many cases, a range of other health services. No other province has taken Ontario's approach.

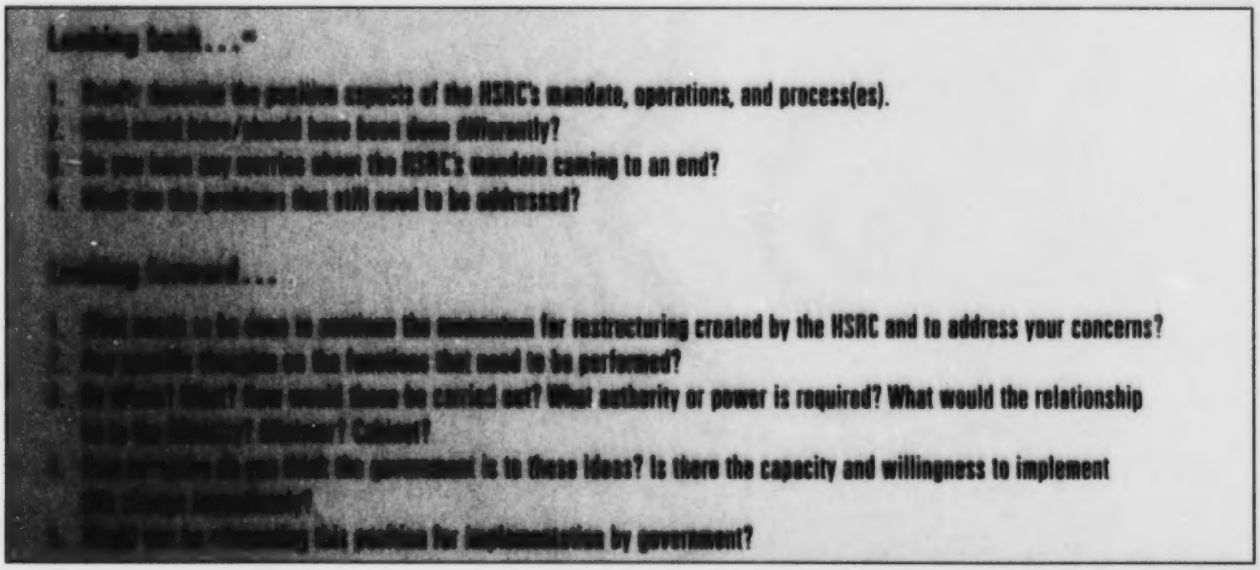
The HSRC learned a great deal over its four years. It wanted to share what it has learned as well as articulate and define what is needed for the continuity of the health restructuring process after the completion of its mandate in March 2000, by identifying:

- The positive (successful) elements of its mandate, process and operations;
- Areas where changes to mandate, process, operations could have produced better and/or different outcomes; and,
- How to maintain momentum for implementation of hospital and other health services restructuring.

To address these issues and elicit a range of views to inform the advice that might be given to government on next steps in the restructuring process a series of interviews were conducted with Commissioners, senior HSRC staff, senior government/MOHLTC representatives, selected hospital representatives and a few key stakeholders who participated in and/or were impacted by restructuring. The interviews were held in November 1999 (see Appendix E for a list of interviewees).

The key questions used in the interviews are highlighted in Figure XIII-1.

**Figure XIII-1: The HSRC – Looking Back, Looking Forward**


Looking back...[85]
1. Briefly describe the positive aspects of the HSRC's mandate, operations, and process(es).
2. What could have/should have been done differently?
3. Do you have any worries about the HSRC's mandate coming to an end?
4. What are the problems that still need to be addressed?
Looking forward...
1. What needs to be done to continue the momentum for restructuring created by the HSRC and to address your concerns?
2. Any particular thoughts on the functions that need to be performed?
3. By whom? When? How would these be carried out? What authority or power is required? What would the relationship be to the Ministry? Minister? Cabinet?
4. What perceptions do you think the government is to these ideas? Is there the capacity and willingness to implement these changes immediately?
5. Should and how should this position for implementation by government?

[85] The interviews and analysis were conducted by Margaret Mottershead, a former Deputy Minister of Health now managing her own consulting business. In essence, the "Looking Back" questions were developed to help inform decision-makers about what mandate, authority and processes worked well and what issues need to be considered by the parties, if similar entities or organizations, or processes are put in place in the future.

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**Looking back...**[85]

1. **Briefly describe the positive aspects of the HSRC's mandate, operations, and process(es).**
2. **What could have/should have been done differently?**
3. **Do you have any worries about the HSRC's mandate coming to an end?**
4. **What are the problems that still need to be addressed?**

**Looking forward...**

1. **What needs to be done to continue the momentum for restructuring created by the HSRC and to address your concerns?**
2. **Any specific thoughts on the functions that need to be performed?**
3. **By whom? What? How would these be carried out? What authority or power is required? What would the relationship be to the Ministry? Minister? Cabinet?**
4. **How receptive do you think the government is to these ideas? Is there the capacity and willingness to implement this change immediately?**
5. **Would you be advocating this position for implementation by government?**

[85] The interviews and analysis were conducted by Margaret Mottershead, a former Deputy Minister of Health now managing her own consulting business. In essence, the "Looking Back" questions were developed to help inform decision-makers about what mandate, authority and processes worked well and what issues need to be considered by the parties, if similar entities or organizations, or processes are put in place in the future.

The opinions and information gathered from these groups were used by the HSRC to assist it in considering the nature of the advice to leave the Government on the issue of continuity of the health services restructuring process in Ontario.

## Summary of Findings

All respondents agreed that the establishment of the HSRC was essential to mobilize the restructuring process, and that the Commission had executed its mandate well. The elements that contributed to the successful execution of the mandate, as well as thoughts on what could have been done differently, are detailed in the sections that follow under the sub-headings "Looking Back" and "Looking Forward".

Strong consensus was expressed regarding the following issues:

- Having completed its task, the HSRC should and must disband as planned.
- Much remains to be done in the restructuring process and on a variety of near term issues ranging from leadership and policy direction (i.e., the need for clear vision of what type of health services system this province wants to evolve to in the future), to the need for funding levers and new financing mechanisms as critical tools for change, to clear accountability for the change and implementation process(es).

There was no consensus on the locus of responsibility for continuation of the restructuring process. Although many respondents agreed there must be a clearly articulated mandate, policy direction, functions and roles of various players in the health system, opinions were divided on where, what type of entity(ies) and who should have authority or become the responsibility centre(s) for health system change, monitoring, and evaluation. Opinions ranged from two extremes –

- The MOHLTC alone or with an advisory body having sole responsibility to implement and affect all decisions related to health services restructuring and health services management
- An independent arms-length commission, corporation, or subsidiary delegated with partial or full responsibility to carry out these tasks.

## Looking Back

When asked to identify the "positive elements" of the HSRC (i.e., those aspects of the HSRC's mandate, operations and/or process, which allowed it to execute its role), the majority of respondents identified the following:

- **Legislated authority** - the legislative power to direct closures, amalgamations, program transfers/consolidations and site changes for any/all public hospitals in Ontario.
- **Relationship** - the establishment of the Commission as an arms-length body from Government with independence of thought, analysis, action and decision. The reporting relationship to the Minister was for the purposes of providing progress reports on its legislated responsibility and advice and recommendations on its non-legislated responsibility.
- **Composition of the HSRC and its operations** - dedicated, talented and committed Commissioners working on a *voluntary* basis toward a common goal; the selection of the individual Commissioners, and the leadership of the Chair, Dr. Duncan Sinclair; the energetic and highly skilled staff of the Commission, and its ability to contract expert advice as needed.

- **Process** – up-front development and communication of the platform (with very clear objectives and values) for decision-making. The process was transparent from start to finish, that is, the development and communication of the review processes, community and public input, published timetables, the basis for analysis (benchmarks and performance targets) and documentation of decisions were all on public record and made available throughout the process. The whole process was consistently applied to allow for the test of due diligence in each case, but included some measure of flexibility to allow for tailoring to unique circumstances (e.g. governance models).

**The resounding response was that *"the Health Services Restructuring Commission did a job that could not have been done by the MOHLTC, the Government of Ontario, or the hospital community, individually or collectively".***

In looking back, one of the questions asked was, "what might have been done differently?" This question was asked not for the purpose of proving that hindsight is almost always 20/20, but to inform or instruct those who may be faced with similar situations in the future. Thoughtful reflection and consideration of these suggestions could potentially influence the end-state or desired outcome. Also, the question was not intended to solicit opinion on the decisions. Its focus was to elicit opinion on adequacy of mandate, operations, or process.

The responses to this question varied significantly between and among respondents. The following lists the suggestions offered in order of magnitude, (i.e., the first suggestion listed below was made by the largest number of respondents, followed by the second suggestion made by the next largest number of respondents, and so on):

- The Government should have given the HSRC a broader mandate to restructure a broader range of health services, starting with restructuring at the primary care level, to and including implementation of hospital restructuring.

- The Government should have provided the policy framework for health services reform, or at the very least, better policy direction or a broad vision of the goals and objectives of the 'reformed' health system.

- The HSRC should have worked concurrently on Phases 1 and 2 of its mandate.

- The HSRC should have issued more directives in its first year of mandate (i.e., worked on more communities concurrently rather than sequentially).

- The Government should have given the HSRC some resource allocation/reallocation powers up front so that its task would not be perceived as a "savings" or budget cutting exercise. This would also have assisted the HSRC in addressing directly both sides of the restructuring equation: hospital restructuring and reinvestment required to support that restructuring.

- The Government should have created a reserve of funds or given commitment and authority to the HSRC to trigger community reinvestments at the same time as directives were issued. Failing this, the Government at the very least, should have harmonized its internal approval processes (MOHLTC, Management Board, Finance, Cabinet) to be able to respond to the reinvestment recommendations in a more timely manner.

- The HSRC should have taken more time and care in planning and executing its public relations program (i.e., stronger focus on public education and better stakeholder management).

- The HSRC should have found a way to bring better balance between statistical evidence (rigorous targeting, benchmarking) and the needs or aspirations of diverse communities (more sensitive to local concerns).

- The Government should have established a Capital Reserve or a Capital Financing Authority, or provided a different capital financing scheme to allow for immediate action on the physical restructuring requirements flowing from the HSRC's *Directions*.

- A better working relationship would have helped between the MOHLTC and the HSRC guided by performance protocols and expectations, each of the other.

Knowing that the HSRC's mandate was expiring in March 2000 and not knowing what the Government's plan was post-HSRC at the time of the interviews, respondents were asked if they had any concerns/ worries about the HSRC's mandate coming to an end and what problems still required attention. While most of the respondents had some concern about the HSRC's mandate ending, their concerns were not so much that the HSRC's technical, authorized mandate was concluding, but that there would be:

- "No body" (i.e., a physical presence/force) to keep pressure on government to continue to implement HSRC directives in the various communities;

- "No body" to keep pressure on government to act on the recommendations for reinvestments in non-acute care required in the various communities;

- "No body" to keep pressure on government to act on the HSRC's advice with respect to key strategic policy issues such as primary care, information management, mental health, northern/rural health, assessment of the performance of the 'system', etc.;

- Loss of the "value-added" dimension brought to bear by the HSRC on health services restructuring;

- Concern that some hospitals will see the end of the HSRC's mandate as an opportunity to stall or completely disengage themselves from negotiations with the Ministry and end-run implementation of *Directions*; alternatively, they will return to the "old days" of direct lobbying of the Minister and bureaucracy;

- Concern that adjustments will be made to directives "for wrong reasons", thereby giving communities that moved forward, reason to pause and perhaps backslide; and

- Concern about MOHLTC's capacity to implement restructuring in a fair, consistent and timely manner.

The following phrase summarizes the sentiments of many of the respondents: *"the biggest risk to continued restructuring is government's inability to make the tough decisions"*.

Many responses to the question of what issues still needed to be addressed in the health care system flowed from the concerns expressed above. The biggest issue seen requiring immediate attention is that of *system governance and leadership*. Leadership (expressed earlier as vision and policy direction) is seen as lacking. In particular, there is a strong belief that players in the health care system will only be able to work more closely together if a leader with a clear vision, direction and authority (and/or delegated authority) is present to bring about system change.

*Health informatics/information management* was cited as another critical issue requiring attention. Decisions at all levels (from policy, to treatment and care) would be better informed if quality data were available and used throughout the health services system.

M121

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Tackling the *primary care system* was also seen as paramount, as well as the implementation of advice on restructuring/reinvestment of mental health, long-term care and home care services in many communities.

There is a need to create a mechanism by which a restructured health services system has the capacity to continually improve its performance through *assessment and monitoring of indicators of health status and health system performance*. The need for *clear accountability and a process for implementation of the HSRC's directives* (including capital forecasting and funding) were also identified as an immediate problem to be addressed.

## Looking Forward: What Next? Where to from Here?

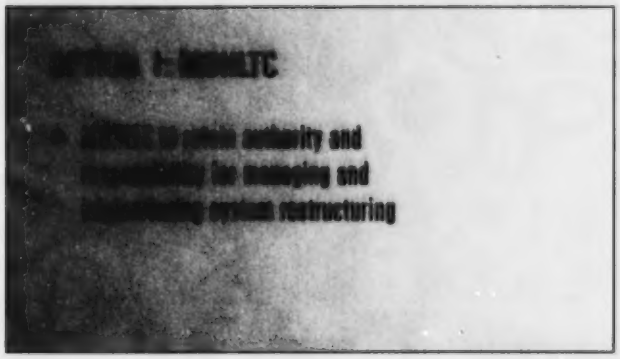
In this section of the interview, respondents were asked to look ahead and give an opinion or advice on what needs to be done to continue the momentum for restructuring created by the HSRC, and to address the issues or concerns that they had identified.

Overall, responses ranged from —

- "The MOHLTC should reclaim its authority and responsibility for health services and further restructuring," to
- "An advisory body composed of highly talented individuals with credibility in the health system should be established to act as watchdog during restructuring and to continue to provide pressure (through presence) on the government to act on other recommendations for change," to
- "The government must establish an arms-length organization with legislative authority to implement whatever changes are determined necessary".

In conducting the analysis of these divergent views of what should happen next to continue the restructuring process, it was clear to the HSRC that most (if not all) respondents recommended "structural" changes as the solution. Four distinct categories (or structural models) emerged as the "most appropriate" entities to continue restructuring and management of Ontario's health system. These are outlined in Figure XIII -2.

**Figure XIII-2: Options for entities to continue restructuring**



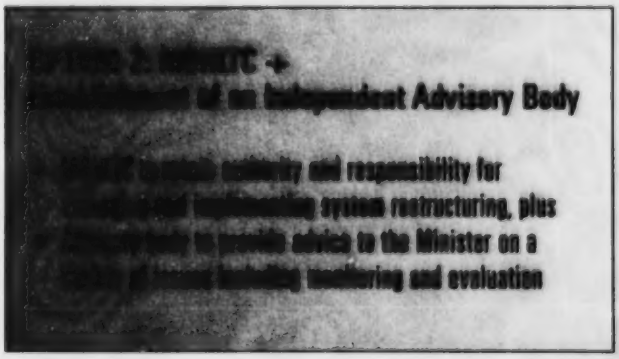


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**Figure XIII-2: Options for entities to continue restructuring**

**OPTION 1: MOHLTC**

- **MOHLTC to retain authority and responsibility for managing and implementing system restructuring**

**OPTION 2: MOHLTC + Establishment of an Independent Advisory Body**

- **MOHLTC to retain authority and responsibility for managing and implementing system restructuring, plus**
- **Advisory body to provide advice to the Minister on a variety of issues including monitoring and evaluation**

**OPTION 3: Establish a Special Purpose [86], Independent Body**

- MOHLTC responsible for general administration of most of the health system, plus
- Establish a special-purpose independent body with legislative authority to implement and manage change in a specific area(s) of the health system
- Agency to operate like a subsidiary company of the major holding corporation (the MOHLTC) and report directly to the Minister and Legislature through the filing of an annual performance report or other reporting mechanism as determined in legislation

**OPTION 4: Establish a Crown Corporation [87]**

- Corporation responsible for the major (if not all of health care services in the province) including governance of the health information system
- Corporation to be established by and report to the Legislative Assembly of Ontario

Regardless of what management models are pursued, those interviewed believe that certain critical factors for success must be present for whoever or whatever entity(ies) is ultimately responsible for continuing the health systems management and restructuring process(es). These factors are:

- **ABILITY:** The government should enable itself or another body to fulfill its role according to the mandate it is given (e.g. the legislated powers must be fully aligned to the mandate of the organization – close hospitals, merge hospitals, realign resources between hospitals, fund new treatment/care modalities in the community, etc.).

- **CAPACITY:** Existing or new entities must have appropriate governance and skilled organization, staff, and be equipped with the best information (based on real time/encounter data, clinical and other performance evidence) and the policy framework or direction from government to make informed decisions.

- **ACCOUNTABILITY:** Existing or new entities must work within an accountability framework (transparent to public) that recognizes the public as payer of the health care system and needs to have a voice and express its satisfaction/dissatisfaction with performance of the health care system. Whatever method of accountability is ultimately chosen, it should be transparent to the public as to what remedy/reward can be applied and what process(es) will be used for the performance review.

These factors, as well as the issues identified in what could have been done differently (looking back on the HSRC) should form the foundation for whatever model is recommended and ultimately chosen by government to continue the work commenced by the HSRC.

[86] The term "special purpose" is used to signify that the mandate of this body would be highly focused and/or time-limited. For example, a hospital services commission, responsible for everything to do with hospitals; or, an information management commission, responsible only for the development and implementation of a provincial health care information system; or, a commission to implement primary care reform; or, a combination of any two or more of the above programs or others (as determined by government) to be first priorities for restructuring.

[87] The term "crown corporation" is used to signify that the crown creates and maintains an interest in the corporation as a holder or owner of public goods/services. Examples include, Ontario Hydro (original entity), Ontario Housing Corporation, Ontario Lottery Corporation, Ontario Arts Council. The Crown Corporations Act would apply and the Corporation would report to the Legislative Assembly of Ontario, or an all-party committee of the Legislature on an annual basis or as determined by the Legislature.

**OPTION 3: Establish a Special Purpose [86], Independent Body**

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## HSRC Deliberations

In deliberations concerning the 'preferred' model, the HSRC acknowledged that –

- The government needs a political "buffer" between it and the difficult decisions that have to be made,
- The MOHLTC, in its current state, may not be in the best position to affect or implement change,
- New solutions must be found, and
- Leadership is required to set policy, create the vision, and the dynamics for change. Whether provided by government or delegated by government to another entity, there was agreement that leadership must exist, be demonstrated at all times and be illuminating to those who must follow.

Although there was no full consensus on who or what organization would best advance the restructuring process, there was agreement that the government should consider the prospects of establishing an arms-length agency with a specific or defined mandate over a part or parts of the health services system. Furthermore, the HSRC believes that the decision regarding the 'preferred' model should be guided by the following:

### The Government (MOHLTC) should...

- Retain authority for overall policy
- Provide leadership and high-level direction to the health system
- Be ultimately accountable for the provision and management of health services. The provincial government has the constitutional responsibility for the provision and management of health care services for its citizens and must therefore retain accountability for its handling of this portfolio, regardless of whether it manages directly or creates and delegates this responsibility to other agents.

### The arms-length 'entity' (i.e., agency, corporation of other body established) should...

- Be arms-length from government and have legislated authority that gives it both responsibility and authority to carry out its mandate
- Report to the Minister of Health and be accountable to the Minister for managing the elements of the system in accordance with the government's policy direction and its own mandate
- Be delegated with authority to carry out — at minimum — the following specific duties and responsibilities:
  - Set performance standards
  - Implement the HSRC's directives
  - Allocate funding among similar health service providers including responsibility for financing capital requirements for restructuring
  - Allocate funds and improve linkages between two or more interdependent areas of health care provision, in the continuum or chain of health care services.

# Section XIV:
# Concluding Remarks

HSRC

# SECTION XIV: CONCLUDING REMARKS

Ontario was not only the last province to approach hospital rationalization, but it also chose to adopt a mechanism different from that tried in other provinces – the establishment of a province-wide, arms-length commission with a limited term to determine what was necessary with respect to hospitals and direct that it be done. Recommendations were also invited by the government on how to restructure other elements of the health system.

In April 1996, the Ontario Government created the Health Services Restructuring Commission and gave it a four-year mandate to catalyze the creation of a genuine health services *system*. The Commission had two 'deliverables':

- To make binding decisions on restructuring Ontario's public hospitals; and
- To make recommendations to the Minister of Health on reinvestments and other changes required to support health system restructuring.

Previous governments in Ontario had considered these issues, but not with a system-wide approach.

Why did the Commission devote the first half of its mandate to hospital restructuring? If the ultimate goal is to create a genuine health services system (which it is) no logic would support dealing first with institutions that are at the end of the line, offering sophisticated services to patients refractory to diagnosis and treatment elsewhere.

The HSRC began with hospitals because in April of 1996 the government had put two major policy planks in place:

- The 'system' would be, at the least, stable financially over the succeeding four years, funded at no less than the then $17.4 billion base budget of the Ministry of Health. Four years later, that funding is now in the $20 billion range, a rate of growth that exceeds inflation by a fair margin. The 'system' is stable financially.

- Hospital budgets would be cut by some 18% over three years at a rate of -5%, -6% and -7%. The last installment of -7%, due in 1998-99, was subsequently deferred pending analysis of just how much money can be safely taken out of the restructured hospital sector, province wide. The Commission's data now support our belief that the total is more like 12 to 13% than 18%.

In any case, the HSRC began with hospitals because it was obvious that serious service disruptions would result if the then 220 public hospitals acted individually to produce the required 11 to 18% budgetary reductions.

Phase I of the Commission's work was, in part, intended to prevent such service reductions. Having begun with hospitals, however, the main objective of Phase I was to lay the foundation of a sensibly sized, rationalized, co-ordinated hospital sector or sub-system. Hospitals organized in this way are essential to provide accessible services of very high quality that are affordable within the limits of a reasonable share of overall provincial spending on health. Such a sector or sub-system is also necessary to render hospitals capable of participating in, if not leading, the development of a genuinely integrated, comprehensive health services system.

As important and interesting as Phase I has been, it is the second phase of the Commission's work that is by far the more challenging and important, primarily because it offers the greater potential for real system-building. Put another way, the HSRC was charged with leading reform of Ontario's health services system by creating a comprehensive, 'seamless' *system* of health and health care services needed to optimize the health of Ontario's population into the 21st century.

Was such a system in place when the Commission 'sun-setted' in March 2000? No, it was not. However, the HSRC hopes that it has produced a completely redesigned hospital sector and identified some of the key strategies necessary to create a more comprehensive, genuine, real *system* of health care services.

It also hopes that its inheritance will include a commitment on the part of Ontario's people and governments to ongoing change — a commitment to the eventual incorporation into a *system* of the whole spectrum of health and health care services necessary to optimize the health of our population.

As the slogan has it, "Built to last means built to change."[88] The future demands that our present non-system change, first into a genuine health care system and subsequently a comprehensive health services system.

[88] Christopher Meyer. Blur: The Speed of Change in the Connected Economy, as quoted by Elizabeth Church, *The Globe and Mail*, July 21, 1998. B13.

# Appendices

HSRC

# APPENDIX A: HSRC MEMBERSHIP AND STAFF

## Membership

**Duncan Sinclair** (Chair), retired Vice Principal
Health Sciences and Dean of Medicine at Queen's University, served as Chair of the Commission. Dr. Sinclair headed the research steering committee for the Premier's Council on Health, Well-Being and Social Justice, and chaired a working group on human resources planning for the Provincial Cancer Network. He was also a member of the National Forum on Health. A long-time resident of Kingston, he retired from Queen's University in June 1996.

**Ruth Gallop**, a Professor and Associate Dean of Research at the Faculty of Nursing at the University of Toronto is also cross-appointed to the Department of Psychiatry and Division of Women's Mental Health at the Faculty of Medicine. She has many years of clinical experience and writes, researches and consults widely on issues related to the provision of mental health care. Dr. Gallop has been a member of the Advisory Board of the Psychiatric Patient Advocate Office for many years.

**Shelly Jamieson**, ExecutiveVice President for Extendicare (Canada) Inc. was previously Executive Director of the Ontario Nursing Home Association. As a former consultant in long-term care, she has worked on diverse projects across the care continuum, from community-based services to chronic care for both the public and private sectors. She is a past Chair of the Ontario Health Providers Alliance, a group of 19 health sector associations committed to ensuring a viable future for Ontario's health sector.

**Harri Jansson**, a financial services executive, has been actively involved in health, social services and non-profit activities across the country. He has served as Chairman of Vancouver General Hospital Foundation, Director of St. Boniface General Hospital in Winnipeg, and was on the board of the Sunnybrook Hospital Foundation (Toronto). He was a member of the Canadian Bankers' Association (Ontario Committee), the Regional Board of the Institute of Canadian Bankers, a Director of Kids Help Phone, and a Director of the Commonwealth Centre for Sports Development. At the time of joining the Commission, Mr. Jansson was Executive Vice President, Central Ontario Division, Personal and Commercial Banking, for the Bank of Montreal. He moved to Vancouver in March 1998 and is currently the President and Chief Executive Officer for Richmond Savings.

**Maureen Law**, a former Deputy Minister of the federal Department of Health and Welfare, recently held the position of Director General of Health Sciences at the International Development Research Centre in Ottawa. Dr. Law served at the Department of Health and Welfare from 1973 to 1989. Dr. Law has also been Deputy Medical Officer of Health in York County and Assistant Professor of Community Health at Queen's University. A physician by training, she served as chair of the Executive Board of the World Health Organization, and has a wealth of other international experience, including involvement in the Global Commission on AIDS and the Global Commission on Women's Health. She is currently Director of Health, Nutrition and Population for the East Asia Region of the World Bank.

**J. Douglas Lawson**, Q.C. a Windsor-based lawyer and senior partner of the McTague Law Firm LLP., has provided legal counsel to district health councils, hospitals and numerous charitable agencies and foundations, and was instrumental in facilitating the merger of the Metropolitan General and Windsor Western hospitals into Windsor Regional Hospital. He is a former President of the Ontario Chamber of Commerce, and founding chair of the Association of District Health Councils of Ontario (ADHCO). Mr. Lawson served as former chair of the Cardiac Care Network Task Force.

**George Lund**, now retired, was Senior Vice President, East, CTV and served as President and Chief Executive Officer of Baton Broadcasting Systems in Northern Ontario since 1989. He began his career as a radio and television broadcaster in Alberta in 1958 before moving to Sudbury in 1962, where he has lived ever since. Mr. Lund served on Sudbury City Council from 1977 to 1980 and was elected chair of the Regional Municipality of Sudbury in 1980. As founding President of Science North, he was instrumental in making the science centre a major attraction in Northern Ontario. Mr. Lund served as a member of a hospital board for a number of years.

**Hartland M. MacDougall**, now retired, was a career banker with the Bank of Montreal across Canada from 1953 to 1984, and served the last four years as Vice-Chairman, before assuming chairmanship of Royal Trust from which he retired in 1993. He was also Deputy Chairman of London Life from 1985 to 1997. He was founding chairman of the St. Michael's Hospital Foundation, the Japan Society and Heritage Canada. He has also served as chairman of the Canada Japan Business Committee, the Council for Canadian Unity and The Duke of Edinburgh Awards International Council. Mr. MacDougall served on a number of hospital boards and a variety of health care organizations across the country during his banking career.

**Muriel J. Parent** is a francophone from Val Rita in northern Ontario where she is president and CEO of three family businesses. She has taught at both the community college and primary school levels. Mrs. Parent has been involved with many social services, health care and municipal initiatives. She has served on the Board of Directors for Sensenbrenner Hospital, the Board of Management for the Cochrane District Homes for the Aged, the Board of Management for North Cochrane Children's Aid Society, and numerous community projects. Mrs. Parent has also been Reeve for the Corporation of Val Rita-Harty.

**Daniel R. Ross**, a London-based lawyer and a managing partner in the legal firm of McCarthy, Tetrault, has an extensive background in the health care system. Mr. Ross was involved in the reorganization of London's Victoria and University hospitals as a member of the merger task force and a past-Chair of the London Health Science Centre Foundation. After the merger he was a member of the hospital's board and executive committee, working on the restructuring and/or amalgamation of the hospital foundations and research organizations.

**J. Donald Thornton**, now retired, has an extensive background in business, financial management and the non-profit sector. As a former executive at General Motors of Canada, he has substantial experience in re-engineering and restructuring. Mr. Thornton was on the Oshawa General Hospital board for 15 years, including serving as chair from 1989 to 1992. He has been an active member of the hospital's foundation and the Parkwood Foundation, as well as the Canadian Chamber of Commerce and the Financial Executives Institute. He is past chair of the Oshawa Harbour Commission.

**Rob C. Williams**, a family physician from Timmins, has served as Chief of Staff at Timmins and District General Hospital since 1992. Dr. Williams has been active in many professional and health care organizations, including the Ontario Medical Association Committee on Hospitals, the Joint Planning and Policy Committee Utilization Steering Committee, and the Canadian Institute for Health Information Physician Advisory Group. He is also co-author of a 1996 OMA document on "Physician's Role in Hospital Restructuring."

## Ex-officio members:

**Peggy Leatt**, who served as the HSRC's CEO from September 1998 to March 2000, was Professor and Chair of the Department of Health Administration of the University of Toronto, a position she held from 1987 to 1998. A widely known and respected expert on issues related to organizational behavior and design, Dr. Leatt has written extensively on health policy and health services design and restructuring.

**Mark Rochon** served as the HSRC's CEO from April 1996 to September 1998. Before joining the Commission, Mr. Rochon served as President and CEO of Humber Memorial Hospital from 1990-96. Prior to this he spent three years as Executive Director of Georgetown Memorial Hospital. Between January 1994 and March 1995, Mr. Rochon was the Assistant Deputy Minister of Institutional Health at the Ontario MOHLTC. Currently, he is President and CEO of the Toronto Rehabilitation Institute.

**David Naylor** served as the HSRC's Special Advisor from March 1996 to March 1998. At the time of his appointment, Dr. Naylor was Chief Executive Officer of ICES (the Institute for Clinical Evaluative Sciences). After earning his medical degree from the University of Toronto, Dr. Naylor was awarded a doctorate from Oxford University, where he studied as a Rhodes Scholar. He chaired the Medical Review Committee's peer review committee on health services research, and sat on various scientific advisory committees and editorial boards. In 1999, Dr. Naylor was appointed Dean of Medicine at the University of Toronto.

## HSRC staff:

Bantock, Peter
Barry, Brenda
Bedkowski, Helen
Bickerton , Margaret
Boggild, Suzanne
Burns, Susan
Cawley, Patricia
Chinapen, Seeta
Cluver, Jane
Defoe, Yvonne
Dharssi, Mehezbin
Dorjee, Jangchap
Eastwood, Carol
Finkelstein, Michael
Finkle, Peter
Flatt, Alexandra
Flemmings, Sonia
Gardner, Chuck
Gasparini, Karen
Geherity, Joann
Hale, Jeffrey
Hales, Beverly
Hooper, Lewis
Jamal, Salima
Karapita, Stephanie
Keshavjee, Khanum
Kilbertus, Paul
Kojori, Sholeh
LePreti, Vic
Lewkowicz, Ruth
Mitchell, Gary
Montgomery, Catherine
Newman, Lisa
Nickoloff, Beverley
Noormohamed, Nasir
Peter, Alice
Purdy, Lisa
Rahal, Rami
Robitaille, Francine
Ruiz, Margaret
Shah, Narendra
Sloan, Bev
Stonehouse, Jim
Sumner, Bernadette
Thorne, Mardi
Tino, Mario
Tremblay, Susan
Trypuc, Joann
Vahabi, Mandana
Varga, Bob
Villafana, Paula
Wight, Laura
Zulys, Helen

The HRSC was ably assisted by many staff over the four years of its mandate. At most times during the Commission's mandate, the office operated with a core staff of approximately 12.

The above reflects a complete list of staff that worked with the Commission. The length of time individual staff members spent at the Commission varied significantly. Some worked with the Commission for only a few weeks while others were employed on a full-time basis throughout the HRSC's four-year term.

# APPENDIX B: LEGISLATIVE DUTIES AND RESPONSIBILITIES

## A. Regulations under Bill 26 — Establishment of HRSC

*(Ontario Regulation 88/96 made under the Ministry of Health Act, March 21, 1996 - Health Services Restructuring Commission.)*

1. (1) The following are the duties of the Commission:

   1. To consider local hospital restructuring plans provided by the Ministry and such other information relevant to the plans as it deems appropriate.
   2. To determine which local hospital restructuring plans provided by the Ministry shall be implemented and to vary or add to those plans if it considers it in the public interest to do so.
   3. To determine the timing of the implementation of local hospital restructuring plans and the manner in which they are to be implemented.
   4. To set guidelines respecting representations that may be made to the Commission by a hospital that has received notice under subsection 6(5) of the Public Hospitals Act that the Commission intends to issue a direction that the hospital cease to operate or that it amalgamate with another hospital.
   5. To give the Minister quarterly reports on the implementation of local hospital restructuring plans.
   6. To advise the Minister where the Commission is of the opinion that a local hospital restructuring plan should be developed for a specified hospital or for two or more hospitals in a geographic area.
   7. Where a hospital fails to carry out a direction issued by the Commission under section 6 of the Public Hospitals Act, to advise the Minister as to appropriate actions, including the appointment of investigators under section 8 of the Public Hospitals Act and of hospital supervisors under section 9 of that Act.

   (2) The guidelines established under paragraph 4 of subsection (1) shall set out the manner in which representations may be made and the procedure for making the representations.

   (3) The Commission may exercise such powers as are necessary to carry out the duties of the Commission including the following powers:

   1. To consult with providers of health care services and such other persons as the Commission considers necessary in order to determine,

      i. which local hospital restructuring plans provided by the Ministry shall be implemented,
      ii. whether and in what manner to vary or add to a local hospital restructuring plan,
      iii. the timing of the implementation of a local hospital restructuring plan, and
      iv. the manner in which a local hospital restructuring plan is to be implemented.

   2. To exercise any power under section 6 or subsection 9(10) of the Public Hospitals Act assigned to the Commission by regulation under that Act.

   3. To advise the Minister as to the revocation of a license under section 15.1 of the Private Hospitals Act.

   4. To advise the Minister on all matters relating to the development, establishment and maintenance of an effective and adequate health care system and the restructuring of health care services provided in Ontario communities.

2. This regulation comes into force on April 1, 1996.

*(Authorization to Issue Directions under Section 6 and Subsection 9(10) of the Public Hospitals Act (O. Reg. 87/96)*

6. (1) The Minister may direct the board of a hospital to cease operating as a public hospital on or before the date set out in the direction where the Minister considers it in the public interest to do so.

(2) The Minister may direct the board of a hospital to do any of the following on or before the date set out in the direction where the Minister considers it in the public interest to do so:

1. To provide specified services to a specified extent or of a specified volume.
2. To cease to provide specified services.
3. To increase or decrease the extent or volume of specified services.

(3) The Minister may direct the boards of two or more hospitals to take all necessary steps required for their amalgamation under section 113 of the *Corporations Act* on or before the date set out in direction where the Minister considers it in the public interest to do so.

(4) When the Minister issues a direction under subsection (3), the Minister's approval of the amalgamation under subsection 4 (1) shall be deemed to be adoption of the amalgamation agreement by all of the members of the amalgamating corporations for the purposes of subsection 113 (3) of the *Corporations Act.*

(5) At least 30 days before issuing a direction under subsection (1) or (3), the Minister shall serve notice of intention to issue a direction on the board of the hospital to which the direction will be issued.

(6) The Minister may make any other direction related to a hospital that the Minister considers in the public interest.

(7) The Minister may amend or revoke a direction made under this section where the Minister considers it in the public interest to do so.

(8) The board of the hospitals shall ensure that a direction of the Minister under this section is carried out in accordance with its terms, this Act and the regulations.

(9) Despite the *Corporations Act*, any special Acts governing hospitals, the letters patent, supplementary letters patent or by-laws of a hospital, the board shall have the unrestricted power to carry out a direction under this section but such powers shall not convene the provisions of any other Act.

(10) The Minister, in issuing Directions under subsection (1), (2), (3) or (6), shall have regard to district health council reports for the communities to which the Directions relate.

(11) This section is repealed on the fourth anniversary of the day section 6 to Schedule F of the *Savings and Restructuring Act*, 1996 comes into force.

9. (2) The Minister shall give the board of a hospital at least 14 days notice before recommending to the Lieutenant Governor in Council that a hospital supervisor be appointed.

(10) The Minister may issue Directions to a hospital supervisor with regard to any matter within the jurisdiction of the supervisor.

# Amendments/Extensions to Legislation

## B. Amendment revoking HRSC powers (April 1999)

*Ontario Regulation 272/99 (made under the Ministry of Health), filed on April 30, 1999, amended the powers of the Commission as follows:*

1. The following are the duties of the Commission:
   a. To advise the Minister on matters relating to the development and establishment of an effective and adequate health care system.
   b. To advise the Minister on the issuance of directions in cases where the Commission issued a draft notice of intention to issue a direction, a notice of intention to issue a direction, a draft direction or a direction before March 13, 1999.

2. Ontario Regulation 88/96 is revoked.

*Ontario Regulation 273/99 (made under the Ministry of Health), filed on April 30, 1999, amended the powers of the Commission as follows:*

1. Ontario Regulation 87/96 is revoked.

## C. Bill 23 — Extension of Minister's powers to 2005 (Nov. 1999)

*Amendments to the Public Hospitals Act:*

On November 30, 1999 the Minister of Health (Elizabeth Witmer), introduced Bill 23 in the Ontario Legislature. Under the Bill, the powers provided to the Minister of Health as described in Section 6 of the Public Hospitals Act, would be extended to 2005, to ensure that changes could be made to *Directions* issued by the HSRC so that they continue
to be relevant.

The Bill provides the Minister with the ability to revise and fine-tune any of the legally binding *Directions* issued by the HSRC allowing for changes to be made that reflect local health care needs. The legislation allows the Minister to continue making *Directions* only to hospitals that have been issued a previous *Direction* or draft *Direction*, that have received a *Notice of Intention to Issue a Direction* or a draft of such a *Notice* or that are established as a result of a *Direction* or draft *Direction*.

# APPENDIX C: HSRC METHODOLOGIES

This appendix provides additional information on the HSRC's methodologies for assessing restructuring options, including sizing and costing of hospital acute care and non-acute services.

## BACKGROUND

A key step in the HSRC methodology was to estimate the following elements of population need for hospital services:

1. Potential *acute care in-patient utilization*[89] *improvements*.

2. Other *hospital service requirements* including:
   - emergency (ER) services
   - ambulatory care services
   - intensive care units
   - operating rooms
   - acute mental health in-patient services
   - long-term mental health in-patient services
   - rehabilitation in-patient services
   - complex continuing care in-patient services
   - sub-acute care services.

3. The impact of changes in hospital service levels on *other health care services* including long-term care facility services and home care services.

4. *Growth in hospital services* including:
   - acute in-patient services
   - ambulatory services
   - emergency services
   - operating rooms
   - intensive care services
   - acute mental health in-patient services
   - long-term mental health in-patient services
   - rehabilitation in-patient services
   - complex continuing care in-patient services
   - sub-acute care services.

These methodologies were utilized to estimate *current* and *future* capacity of hospital and other health care services. In addition, it was necessary to estimate the size of service requirements to help develop different scenarios or options for restructuring hospital services.

## SIZING AND CONFIGURATION OF HOSPITAL SERVICES

### Background: Assessment of Acute Care Requirements[90]

The starting point for the HSRC's analysis was to assess current and future requirements of the hospital system. The largest component of this system relates to in-patient acute care services, accounting for approximately two-thirds of hospital costs. To assess these requirements the HSRC considered two aspects of in-patient acute care:

[89] The utilization improvement methodology was developed with particular focus on improvements which were both manageable under certain conditions and likely to occur in the Ontario hospital system. There may be further improvements identified through various means including the application of utilization tools that can be used either retrospectively or concurrently within individual hospitals.

[90] The basic acute care utilization improvement methodology was based on previous work undertaken by the MOHLTC and the Joint Policy and Planning Committee (JPPC). The methodology reported in the Planning Decision Support Tool (PDST) was used as the foundation of the HSRC methodology for utilization improvement in hospital in-patient acute care. Adaptations to the method were developed by the HSRC and these changes were shared with the Ministry and the JPPC as developed and implemented by the HSRC.

- *current* requirements if utilization improvements are achieved
- *future* requirements based on population growth and service expansion.

The following principles informed the development of the methodology:

- Utilization improvements should not threaten patient access to necessary hospital services or diminish overall quality of care.
- Existing methodologies to assess potential utilization improvements should be used wherever possible.
- The most recent available in-patient separation abstract data (CIHI database) should be used for assessing appropriate utilization.
- Current definitions of data elements and current medical technologies should be assumed.

The methodology applied benchmarking techniques and definitions of *potentially conservable in-patient activity* that were specific to the Ontario context. The methodology for assessing conservable patient days was based on a retrospective analysis of clinical data included in the in-patient abstracts submitted by hospitals to CIHI. In other words, all benchmarks, and the identification of potentially conservable days were derived from clinical practice already being achieved in Ontario hospitals on the basis of the most recent clinical data available at the time.

Even though the most recent data available were used, there was a significant lag in "current data" so that usually the improvements suggested by the HSRC's methodology were likely to be achieved two to three years earlier in the system.

## Methodology: Overview of assessment of acute in-patient utilization improvements

- The basis of the HSRC's methodology to determine the current requirements for in-patient acute care services was based on a review and analysis of hospital utilization data and the potential for improvement in the delivery of in-patient acute care services. Based on the most recent annual data available at the time (1995-96) the data were "trimmed" to remove:
  - Out-of-province cases and days
  - Mental health cases and days in designated mental health facilities
  - Newborns
  - Days beyond a 365-day length of stay.

- Removal of the potential improvements in utilization and the addition of future requirements allowed for current capacity to be compared with the required capacity. Options for restructuring resulted from these comparisons.

- A number of the HSRC reports noted large variations in hospital admission rates throughout Ontario. The acute in-patient utilization improvement methodology focused upon the potential to *conserve in-patient acute activity and assumed that current hospitalization patterns will continue.* Hospital admission rates (or the 'propensity to admit') were therefore not reviewed in any significant level of detail; however, it is clear that further research is needed in this area.[91]

- The approach was based on a series of steps whereby conservation of the patient days associated with each step in the analysis resulted in a

[91] The HSRC, in conjunction with the JPPC attempted to assess the factors related to "propensity to admit" early in its mandate. This work provided important input into the work on volumes related to the funding formula initiative. The work, however, merely addressed some potential influences and was inconclusive as to firm data on reasons for the variation. ICES has also addressed small area rate variation for many services and procedures performed in hospitals. Research is ongoing to understand the underlying causes of both types of variation.

residual level of patient days which was interpreted as the appropriate, achievable level of in-patient acute utilization.

- The methodology specifically reviewed only acute in-patient data. Other activities associated with designated in-patient services such as acute mental health (psychiatric), rehabilitation or complex continuing care beds were not addressed. If these services were delivered in acute in-patient beds, and the facility in question was not designated to provide them, then utilization improvements were assessed.

- For the most part, conservable days were aggregated and reported for each of the following five age groups: 0–14; 15–44; 45–64; 65–74; 75+. The growth methodology (further details provided below) employed a finer breakdown of age based on five (5) year cohorts for both sexes.

- Calculations to estimate and eliminate the days of stay that could be considered "conservable" were undertaken. Conservable days and cases were identified in three stages of the methodology:
  - elimination of alternate level of care (ALC) days
  - elimination of avoidable admissions
  - reduction in average length of stay (ALOS).

- *Out-of-Province Separations and Days:* Unless otherwise indicated through policy changes or other circumstances, the acute patient days and acute cases excluded from the analysis of potentially conservable days were added back to the total appropriate acute days to establish the appropriate number of acute days necessary. Where growth in out-of-province caseload and in-patient acute days was predicted by special reports or other considerations this growth was added to the total. These days were then used to establish the acute in-patient bed requirements.

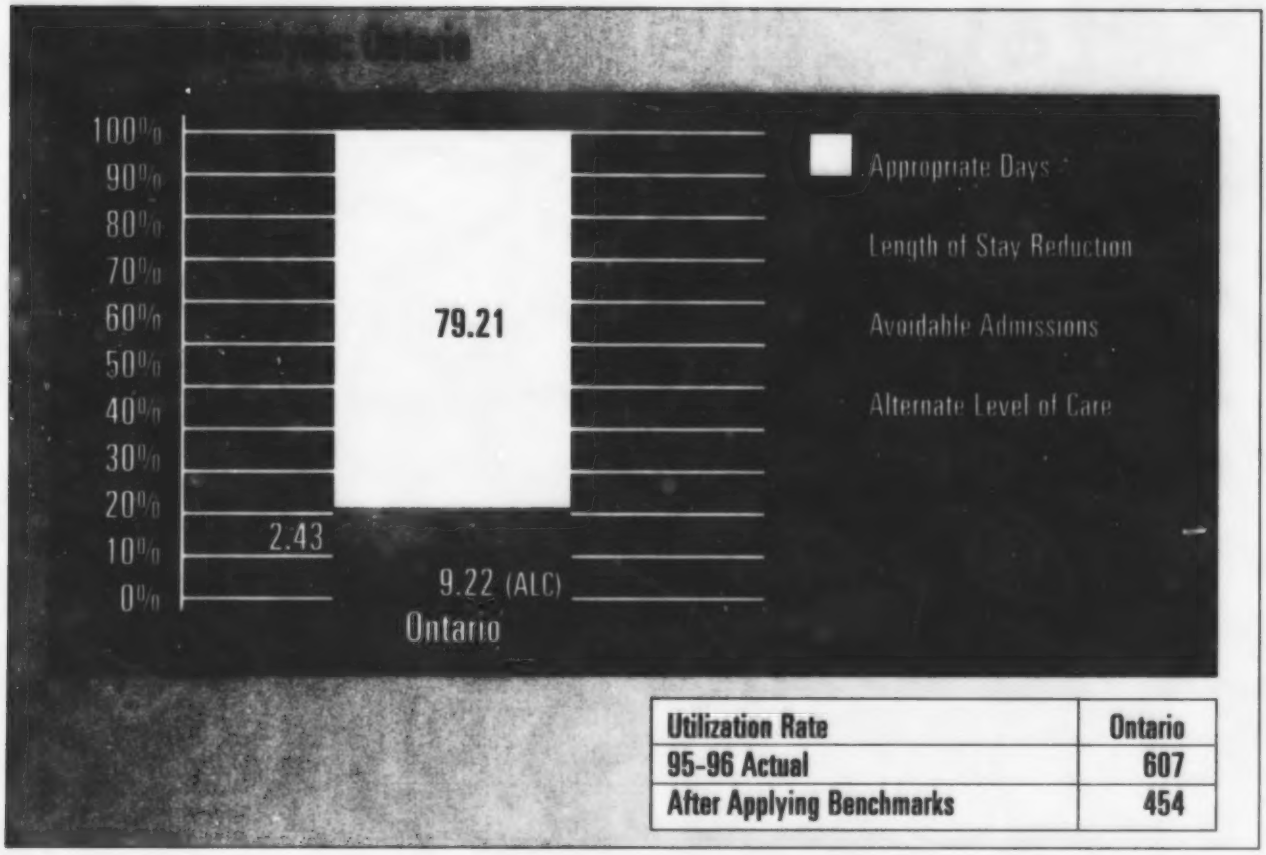
- The steps specified in the methodology were mutually exclusive (i.e., when a potential improvement was identified and calculated the cases and days were removed from further consideration in the methodology). The sole exception was ALC cases and days. In this instance ALC had two length of stay components:
  - Acute days associated with the case in advance of the time the patient was deemed to require an ALC other than acute care; and
  - ALC days, or days stayed in hospital subsequent to the time the patient was deemed to require an alternate level of care.

- While the ALC days were removed, the acute days were further considered in the methodology for ALOS adjustment based on the application of benchmarks.

- The categories of utilization improvements/ inappropriate utilization backed out of existing acute (non-psychiatric) utilization were:

### Sum of Conservable Days:

The sum of conservable days associated with the categories outlined above, when removed from the total patient days, results in the residual or appropriate patient days. This relationship and the relative contributions of each category of conservable days is illustrated in the diagram below:




| Utilization Rate | Ontario |
|---|---|
| 95-96 Actual | 607 |
| After Applying Benchmarks | 454 |

***Thus, in 1995-96, approximately 20 per cent of acute patient days, subsequent to the removal of the exclusions noted earlier, were assessed to be conservable. As a result the residual acute days represented approximately 80 per cent of the acute patient days, subsequent to the removal of exclusions. With respect to utilization rates, the effect would be (based on 1995-96 data) a reduction in the rate from 607 acute patient days per 1000 population to a rate of 454.***

# GROWTH METHODOLOGIES

### Estimating Growth in Acute In-patient Days

- The allocation of funding prospectively to hospitals in areas of high population growth required a method of estimating the growth in in-patient and day surgery caseload due to population changes (taking into consideration growth and the changing age and sex structure of the population).

- The HSRC method required the allocation of growth in acute in-patient activity to specific hospital programs after utilization improvements had been taken into account.[92]

[92] The HSRC method required the allocation of growth in acute in-patient activity to specific hospital programs after the utilization improvements had been taken into account.

- Both the growth funding method and the estimation of future growth in acute in-patient cases and days involved four basic steps:

| | |
|---|---|
| **Step 1** | **Determine population change** |
| **Step 2** | **Calculate the impact of population change on the utilization of hospital services** |
| **Step 3** | **Allocate the impact of population change to hospital acute in-patient programs and day surgery** |
| **Step 4** | **Calculate equivalent beds by hospital** |

### Step 1: Determine population change

Population projections provided by the Ontario Ministry of Finance were used in the methodology to determine population change. The population projections were set for specific gender and age group (i.e., age-sex cohorts). Five year age groups were used (i.e., 0-4, 5-9, etc.). Projections were made to the county level. These projections were also evaluated at an even finer level based on census sub-divisions within a county.

The following table **A** illustrates how nominal projected population growth was calculated, using the example of Hamilton-Wentworth. Its population was projected to grow at a rate of 1.54 percent annually between 1995 and 2003. While the chart shows only overall population growth estimates, it should be noted that these growth rates exist for each age-sex cohort.

### Step 2: Calculate the impact of population change on in-patient acute care utilization

The approach was to create mean hospitalization rates for each Case Mix Group (CMG) (approximately 550) and age-sex cohort at the provincial level for 1995-96 and apply these rates to projected population estimates by age-sex cohort for the year 2003. To compensate for wide variation in hospitalization, provincial mean rates were used to project hospitalization rather than the county specific rate. This means that *counties were treated equitably for growth regardless of whether they currently over/under-utilize hospital resources.*

| | | | | |
|---|---|---|---|---|
| Expected Utilization Rate = | Weighted Cases 95-96 (Province) (by age/gender/CMG) | / | Projected Population 1995 (Province) (by age/gender) | |
| Expected Weighted Cases = | County Population (by age/gender) | X | Expected Utilization Rate (by age/gender/CMG) | |

Weighted cases associated with a CMG for a particular age-sex cohort (e.g., CMG 194, male, 40-44) were used as the numerator divided by the age-sex cohort population to achieve the expected utilization rate. These rates were then applied to the age-sex cohort projected population to establish the expected weighted cases in the year 2003. For day surgery Day Procedure Groups (DPGs) were substituted for CMGs.

**A**

| County/Region | Pop'n projections 1995 | Pop'n projections 2003 | % annual growth |
|---|---|---|---|
| Hamilton-Wentworth | 497,172 | 558,465 | 1.54 percent |

| [redacted]/Region | % annual population growth | % annual hospitalization growth normalized |
|---|---|---|
| [redacted]-Wentworth | 1.54% | 2.28% |

While population growth in Hamilton-Wentworth is projected to grow by 1.54 percent annually as a result of the population change, hospitalization is expected to grow at a rate of 2.28 percent annually (see table B. ). The difference is due to the changing age structure of the population and the correlation of hospitalization and age.

### Step 3: Allocate the impact of population change to hospital acute in-patient programs and day surgery

The HSRC used a definition of hospital in-patient programs based on a program clustering comparable to that developed by Price-Waterhouse Consultants in the Essex County DHC Report — *Reinvesting the Savings* (1994). These programs (25 in total, including pediatrics) were roll-ups of CMGs specific to a particular cluster of services, such as General Medicine. The programs within the HSRC methodology could be transferred between hospitals in whole or in part for the purposes of developing different restructuring options.

Allocation of growth to programs within hospitals, after removing conservable days, was then based on a blend of two methodologies:

i. actual (i.e., historical) hospital referral patterns (50 per cent);
ii. proximity (50 per cent).

The historical utilization pattern assumed that the pattern of use would be constant over time.

The HSRC method assumed this to be true for only 50 per cent of new cases. For the balance, it was assumed that proximity to the facility would affect hospitalization. That is, estimates of future referral patterns based on patient preference assumed that the closer a patient lives to a hospital, the more likely they will be to seek services from that facility, taking into account available services and hospital locations.

### Step 4: Calculate equivalent acute beds for the year 2003

Determining the number of beds required summing the growth in patient days to the year 2003 by all programs assigned to the hospital for each option under consideration. Converting acute in-patient days to beds was a matter of dividing by 365 days and adjusting for the benchmark occupancy rate.

For individual hospitals the process was similar: begin with totalling the programs assigned to the hospital under a particular option; adjust for utilization improvements (i.e., remove the estimated conservable days for ALC cases, reduced admissions and reduced LOS). Add the days related to the estimate of growth. Divide by 365 days and adjust for the benchmark occupancy rate.

| | | | | |
|---|---|---|---|---|
| Current Utilization (95-96 acute days) | - | Conservable Utilization (ALC, Avoid.Adm,ALOS) | = | Post Utilization Mgmt (acute days remaining) |
| Post Utilization Mgmt (remaining acute days) | + | Growth | = | Acute Utilization (2003) |
| Acute Utilization 2003 / 365 X (100/benchmark occupancy) | | | = | Acute Beds (2003) |

### Example of Calculation of Growth in Acute In-patient Days

| [redacted]/Region | Adjusted Days | Post Utilization Management Days | Days Adjusted for Growth | Equivalent Beds 2003 | Equivalent Beds 1995-96 | Growth in Equivalent Beds |
|---|---|---|---|---|---|---|
| [redacted]-Wentworth | 399,695 | 295,011 | 348,374 | 1060 | 898 | 162* |
| [redacted] to accommodate growth to the year 2003) | | | | | | |

### Estimating Growth in Emergency (ER) Visits and Ambulatory Care Visits

- There is insufficient precision in the data reported by hospitals respecting ER visits and ambulatory care visits (not including day surgery) to have replicated the above methodology for ER and ambulatory care. Thus, the HSRC approached the growth in these services in relation to the growth in acute care based on two assumptions:

  i. ER visits were related to the availability of acute beds (including acute mental health beds)
  ii. Ambulatory care visits would grow at a rate comparable to the growth in acute in-patient care

**ER Visits:** To establish a relationship to beds the HSRC established a ratio of ER visits to post-utilization management beds plus the acute mental health beds (based on the planning ratio for acute mental health). This ratio was calculated using current ER visits divided by the beds after utilization improvements were removed with the addition of the acute mental health beds. The ratio was then compared to the 2003 acute bed level plus the acute mental health bed requirements in 2003. By multiplying the ratio by the sum of these two bed levels an estimate of expected ER visits was produced.

(Post Utilization Mgmt (beds) + Acute Mental Health) / Current ER Visits (beds) = ER Services Ratio

Post Utilization Mgmt (beds) + Growth + Acute MH 2003 (beds) = Acute Beds 2003 (beds)

Emergency Services Ratio X Acute Beds 2003 = ER Visits 2003

The same approach was used to estimate the required capacity for ambulatory visits. The number of ambulatory clinic visits (not including day surgery) includes all general and speciality clinics and day and night care.

## BENCHMARK OCCUPANCY RATES

Benchmarks were based on a number of reviews of Ontario hospital systems earlier in the decade. These reviews were, in turn, based on the U.S. experience. The rates were then tested against real occupancy data in Ontario hospitals. The rates allowed for flexibility in bed use and normal variations in ER and urgent access by patients to in-patient resources.

Based on queuing theory, a relative factor of occupancy was developed and applied to other hospital size configurations. In the case of hospital occupancy rates, the service cost is high bed inventory resulting in a higher than 'needed' vacancy rate. The waiting cost is a cost to patients' care, such as, a patient may not be admitted until a bed becomes available, or a patient may be transferred to another hospital.

As a starting point, the occupancy rate of 90 per cent for a hospital size of 200-299 beds was accepted. Using the model formulas, respective occupancy rates were calculated for other bed size groups. The smaller the hospital, the lower the calculated occupancy to balance the system cost without compromising patient care. As an added measure of conservatism the HSRC occupancy benchmarks never exceeded the 90 per cent rate for medical beds. A further consideration addressed the extent to which very high occupancy rates resulting from merging sizeable clinical activity would be achieved. To overcome this, 90 per cent was set as the highest occupancy rate to be used for sizing of facilities. Ninety per cent occupancy for medical/surgical activity was used in the *Report of the Hospital Restructuring Committee*, Metropolitan Toronto District Health Council (September 1995).

In a final step, the calculated hospital occupancy rate, by the bed size groups, was distributed to reflect the variable occupancy rates by the designated acute care levels. It is this final distribution, by level of care, that is used as the benchmark rates for different bed size groups in the methodology.

The total overall occupancy benchmark for all in-patient acute services (excluding psychiatry and newborns) is a weighted average of the benchmarks across all the categories of bed. This was calculated as follows:

**Total Weighted Benchmark Occupancy =**

$$\sum_{n+a}^{d} (OOC_n * Beds_n)$$

Where, OCC = Benchmark occupancy rate
Beds = Number of beds staffed and in operation
a = Medical/Surgical
b = Obstetrics
c = Paediatrics
d = Special Care (ICU/CCU)

= Total Weighted Acute Benchmark Occupancy Rate

The benchmark rates were meant to be used only as indicators. Other considerations such as acuity of care, nature of acute services (e.g., secondary, tertiary, etc.), size of units and other factors must be taken into account for planning.

# FUNDING/COSTING METHODOLOGY

Because the assessment and estimation techniques were new, the HSRC realized that input to its methodologies was fundamental to obtaining the best results. Further development and research based on feedback was a basic component of the HSRC process. Therefore, in every HSRC restructuring report, the HSRC solicited feedback on the methodologies by including an appendix summarizing the methodologies used, and holding a technical briefing of stakeholders during the *Notice* period to discuss questions regarding the methodologies. In addition, the briefings provided stakeholders with additional information to better prepare their responses to the report and *Notices*. These responses frequently addressed questions about the methodology.

# POPULATION AND DEMOGRAPHICS

## Referral Population
## - Expected Stay Index (ESI) Referral Population

The ESI captures the effect of hospital specific CMG distribution and patients' age on the hospital acute length of stay. For hospitals with resident populations which are older and/or more complex than the provincial distribution, the effect of the ESI adjustment is to increase the calculated referral population and thus decrease the patient day utilization rates. Conversely, for hospitals with comparatively younger and less complex resident populations, the effect has been to decrease the calculated referral populations and, consequently, to increase the patient day utilization rates.

### Calculation of Hospital Specific Expected Stay Referral Population and Patient Day Utilization Rate

The calculation of the ESI hospital referral populations is performed in five distinct steps:

Step 1: Calculate hospital base referral population
Step 2: Calculation of hospital expected length of stay (ELOS)
Step 3: Calculate provincial ELOS
Step 4: Calculate hospital specific ESI
Step 5: Calculate hospital specific ESI Referral Population.

Using the results provided in step 5, the hospital specific ESI patient day utilization rate can be calculated.

The primary advantage of the ESI referral population methodology is that it accounts for the acuity and/or complexity of individual hospital visits. The method acknowledges that Hospital A will take more days to treat its heart transplant patient than Hospital B will take to treat its tonsillectomy patient, even though the two patients are within the same age group. The

patient day utilization rates predicted by the ESI model are consistent with what is intuitively expected based on the case mix and age distribution of hospital referral populations. Expectations of the model are as follows:

- **Tertiary hospitals**, because of the higher acuity of cases treated, would be expected to show higher than average ESIs and, hence (when compared to last year's Age-Weighted model) higher referral populations and lower patient day utilization rates.

- **Specialty hospitals**, with short stay cases, would be expected to show lower than average ESIs and, hence (when compared to last year's Age-Weighted model) lower referral populations and higher patient day utilization rates.

- **Community and rural hospitals**, with less complex case loads and high frequency of transfers would be expected to show lower than average ESIs, (unless the ESI was balanced by a referral population of above average age) and, hence (when compared to last year's Age-Weighted model) lower referral populations.

## Estimation of Costs and Savings Associated with Acute Care

The research activities undertaken by the HSRC in developing and reviewing the cost/ savings methodology concentrated on the following areas:

- Estimating costs and savings derived from ***clinical efficiencies***
- Estimating costs and savings derived from ***consolidation of support services***
- Estimating costs and savings derived from ***improvement in administration***
- Estimating costs and savings derived from ***fixed costs of plant operations*** in hospitals
- Estimating costs and savings related to ***program transfer*** (i.e., restructuring savings)
- Costs of activity other than in-patient acute care such as ***ambulatory activities, chronic care, rehabilitation and mental health***
- Estimation of ***cash flow*** adjustments
- Estimation of ***reinvestment*** requirements to mitigate effects of restructuring.

The HSRC developed software to automate the process of estimating costs and savings associated with various restructuring options using the methodology. Automation was necessary for assessing options related to large scale restructuring reviews where numerous competing options needed to be considered.

The research that the HSRC engaged in to develop and refine the approach to ***estimating savings from clinical efficiencies*** followed three complementary paths:

i. Review of actual cost experiences of the Ontario full case cost[93] hospitals (i.e., those hospitals that had the capability of identifying per diem costs and breakdowns).
ii. Use Ontario Cost Distribution Methodology as the basis for determining direct and indirect case costs.
iii. Use expert advice to determine model for efficiencies and savings in support services.

At the base of the methodology were assumptions respecting conservable days associated with:

- Removal of all ALC days
- Reduction of days (and cases) associated with:
- CMG 851 - other factors causing hospitalization
- CMG 910 - diagnoses not generally hospitalized
- Conversion of in-patient surgery to day surgery

[93] Case Cost Hospitals refers to hospitals that are participants in the Ontario Case Costs Project.

M121

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- Twenty-five percent reduction of the days associated with May Not Require Hospitalization (MNRH) CMGs
- Reduction of acute average length of stay (ALOS) to benchmark (i.e., 75th percentile) levels.

In addition to these savings the HSRC method estimated savings associated with restructuring in the following ways:

- transfer of clinical (in-patient) activity between hospitals
- reduction in administrative costs
- consolidation of support services
- reduction in plant costs.

### Costing Methodologies

The HSRC costing methodologies were developed to identify the costs and savings associated with restructuring options and more specifically:

- To assist the HSRC in assessing the affordability criterion for various restructuring options by building on approaches consistent with industry practices and methodologies currently in place.
- To determine the extent of savings associated with: clinical efficiencies; consolidation of support services; administrative overhead; costs of plant operations.
- To develop Advice for the Minister of Health on the expenses and savings estimates associated with HSRC *Directions* and Recommendations.

**Cost centres included in the direct cost/day for all of the methodologies were:**

- **Nursing In-patient Services (including the OR and Recovery Room)**
- **Ambulatory Care Services (related to the in-patient stay)**
- **Clinical Laboratory Services**
- **Diagnostic Imaging Services**
- **Pharmacy**
- **Clinical Nutrition**
- **All of the therapies (e.g. PT, OT, RT, etc.)**
- **Food Services**

Treatment of medical staff expenses: The salaries of physicians providing direct patient care were included in the direct cost per day (e.g. pathologist). However, the cost of running the medical services department (including the Chief of Staff) were considered part of an administrative functional centre and were treated as indirect.

### Estimating the Costs of Rehabilitation Care

- The methodology was applied to hospitals with rehabilitation care beds in 1995-96 and those where beds were recommended for 2003.

- The steps involved in the methodology were as follows:
  - Step 1: Determine net rehabilitation care expenses
  - Step 2: Estimate costs associated with program reductions/enhancements
  - Step 3: Calculate allied health expense adjustment
  - Step 4: Estimate site closure expenses
  - Step 5: Transfer of plant expenses to other patient activity
  - Step 6: Administrative allocation
  - Step 7: Add back selected expenses.[94]

[94] For institutions that remain open, selected expenses are added back. If the rehabilitation care program is closed then the selected expenses are not added back and are included in the savings.

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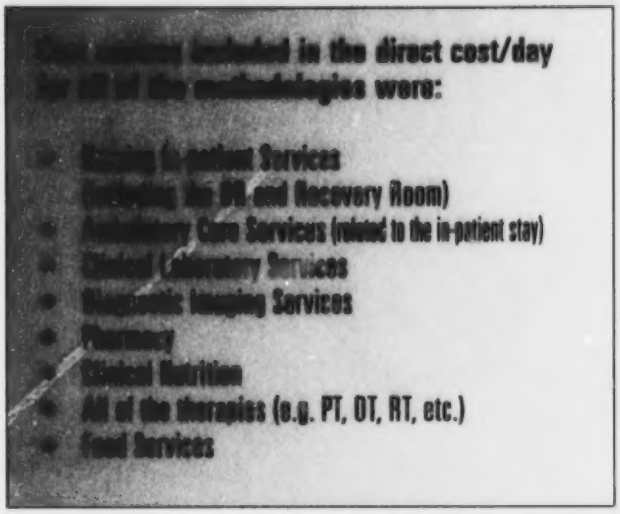


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- The addition and/or subtraction of the above steps estimated the cost of the re-configured system. The savings/costs were attributed to the change in coverage and amount of future service.

### Estimating the Costs of In-patient Mental Health

**Costing Acute Mental Health Beds:** The costs of acute mental health beds were estimated using an acute mental health per diem multiplied by 365 days multiplied by a 90% occupancy rate. The acute mental health per diem was calculated based on the direct psychiatric nursing cost/day of all acute care facilities with an adjustment for diagnostic, therapeutic and outpatient costs related to the in-patient stay. The adjustment was equal to 22.75% and was derived based on free-standing mental health facility costs. The median cost of $209.58 was used as the per diem. An administrative benchmark was then applied at the benchmark to the direct cost to determine a new full cost.

**Costing Child and Adolescent Beds:** The method of estimating the costs of child mental health beds used a child mental health per diem multiplied by 365 days multiplied by a 70% occupancy rate. The child mental health per diem was calculated based on the direct psychiatric nursing cost/day of the four children's hospitals with an adjustment for diagnostic, therapeutic and outpatient costs related to the in-patient stay. The adjustment was equal to 22.75%. The median cost of $275.70 was used as the per diem. An administrative benchmark was then applied at the benchmark to the direct cost to determine a new full cost.

**Costing Longer Term Mental Health Beds:** The direct cost/day of the specific PPH under review multiplied by 365 days (a 100% occupancy rate) was used to estimate the costs associated with the change in longer term mental health beds. Direct costs included: nursing, diagnostic and therapeutic services, and ambulatory services related to the in-patient stay. Where it was difficult to determine if a cost centre is direct or indirect it was included in the direct cost/day to allow for a more conservable estimate of costs. An administrative benchmark was then applied at the benchmark to the direct cost to determine a new full cost.

**Costing Forensic and Ambulatory Care Services:** Direct care costs for forensic and ambulatory care services were determined based on financial reports of the PPH in the region under review. These costs were transferred from the PPH to other facilities considered in the option at full direct cost. An administrative benchmark was then applied at the benchmark to the direct cost to determine a new full cost.

**Costing Complex Continuing Care:** The following steps outline the methodology applied to hospitals with chronic/palliative care beds in 1995-96 and recommended complex continuing care beds in 2003:

Step 1: Determine net chronic/palliative care expenses
Step 2: Estimate the costs associated with program reductions/enhancements
Step 3: Calculate resource intensity adjustment
Step 4: Estimate site closure expenses
Step 5: Transfer of plant expenses to other patient activity
Step 6: Determine administrative allocation
Step 7: Add back selected expenses.

Estimating the cost of the re-configured system involved some or all of the above steps. The savings/costs were attributed to the change in three aspects of complex continuing care: intensity of future service; the amount of future service; and, the type of unit (acute or free-standing).

# APPENDIX D: HUMAN RESOURCES AND LABOUR ADJUSTMENT - ADDITIONAL BACKGROUND

**[redacted] FOR RECONFIGURATION**[95]

***[redacted] FOR ALL MAJOR STAKEHOLDERS – In human resources terms, this means the ability [redacted] within a constantly changing system (commitment to voluntary exits, retraining and [redacted] during transitional periods) and to find ways that make it possible for employees to achieve [redacted] for participating in reconfiguration (seniority, transferability of benefits, [redacted], co-ordinated, proactive retraining programs).***

## HSRC Consultation Participant List

**Consultation Panel**
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Mario Tino, HSRC staff
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Broader Public Sector Unit
Management Board of Cabinet

[95] *The Essex County Win/Win Model: An Evolving Plan for Total Health System Reconfiguration*, The Final Report of the Steering Committee on Reconfiguration, Essex County District Health Council, February 1994, p. 154. This report was widely circulated and expressed the principles manifest in many of the human resources plans developed under HSRC *Directions*.

# APPENDIX D: HUMAN RESOURCES AND LABOUR ADJUSTMENT - ADDITIONAL BACKGROUND

## VALUES AND GOALS FOR RECONFIGURATION[95]

***TO ACHIEVE WINS FOR ALL MAJOR STAKEHOLDERS – In human resources terms, this means the ability to deliver employment security within a constantly changing system (commitment to voluntary exits, retraining and low income replacement during transitional periods) and to find ways that make it possible for employees to achieve the principle of no income disadvantage for participating in reconfiguration (seniority, transferability of benefits, system-wide equity in remuneration, co-ordinated, proactive retraining programs).***

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Suzanne Silk Klein, Pathe Gardner Associates

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# APPENDIX E: LOOKING BACK/LOOKING FORWARD

### Purpose of Project

To determine what is necessary for continuity in health services restructuring post completion of the HSRC's mandate in March 28, 2000.

**Commissioners**
- Duncan Sinclair, Chair
- Ruth Gallop
- Shelly Jamieson
- Maureen Law
- Doug Lawson
- George Lund
- Hartland M. MacDougall
- Muriel Parent
- Daniel Ross
- Donald Thornton
- Rob Williams

**Government and MOHLTC Representatives**
- John King, Assistant Deputy Minister, MOHLTC
- David Lindsay, President & CEO, Ontario Jobs & Investment Board
- Jeffrey Lozon, Deputy Minister, MOHLTC
- Perry Martin, Premier's Office (former Exec Asst. to the Minister of Health)
- John Oliver, Assistant Deputy Minister, MOHLTC
- Jenny Rajbalsley, Director, Health Implementation Restructuring Team (HIRT), MOHLTC

**Other stakeholders *(hospitals and other health service related organizations)***
- Arnie Aberman, Past Dean of Medicine, University of Toronto
- Tom Closson, Victoria, B.C. Regional Health Authority and past President and CEO, Sunnybrook Health Sciences Centre (Toronto)
- Mary Duggan, President & CEO, London Health Sciences Network
- Alan Hudson, President & CEO, University Avenue Health Network
- Ronald Stanford, COO, Hamilton Health Sciences Centre, and past Assistant Deputy Minister of Health
- Vicki Thomas, Executive Director, Ontario Nursing Home Association
- Lorne Zeis, Vice President, Markham & Stouffville Hospital, past Executive Director, Metro DHC

**Special Advisor to the HSRC**
- Daniel Neylon, Dean of Medicine, University of Toronto

**HSRC Staff (past and present)**
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- Mark Rochon, Past CEO
- Peter Fields
- Dorothy Nicholoff

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- Lorne Zon, Vice-President, Markham & Stouffville Hospital, past Executive Director, Metro DHC

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- Mark Rochon, Past CEO
- Peter Finkle
- Beverly Nickoloff
- Mario Tino

# LIST OF HSRC PUBLICATIONS AND REPORTS

## Restructuring Reports (22 communities)

| REPORT TITLE | NATURE OR CONTENT OF REPORT | DATE OF RELEASE |
|---|---|---|
| **BRANT COUNTY** | | |
| Brant County Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | November 1997 |
| Brant County Health Services Restructuring Report | Directions and Advice | May 1998 |
| **LEEDS & GRENVILLE (Brockville)** | | |
| Brockville Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | November 1997 |
| Brockville Health Services Restructuring Report | Directions and Advice | February 1998 |
| **ESSEX COUNTY (Windsor)** | | |
| Essex County Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | October 1997 |
| Essex County Health Services Restructuring Report | Directions and Advice | February 1998 |
| **FRONTENAC, LENNOX AND ADDINGTON (Kingston, Napanee)** | | |
| Frontenac, Lennox and Addington Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | February 1998 |
| Frontenac, Lennox and Addington Health Services Restructuring Report | Directions and Advice | June 1998 |
| **GTA/905 (Durham, Halton, Peel, And York Counties)** | | |
| GTA/905 Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | November 1997 |
| GTA/905 Health Services Restructuring Report | Directions and Advice | April 1998 |
| GTA/Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice: Medical Human Resources Planning | April 1998 |
| GTA/905 Health Services Restructuring Report | Notices of Intent to Issue Supplementary Directions: Governance Plan for the Amalgamation of Memorial Hospital, North Durham Health Services, Oshawa General Hospital and Whitby General Hospital | June 1998 |

| | | |
|---|---|---|
| GTA/905 Health Services Restructuring Report | Supplementary Directions: Governance Plan for the Amalgamation of Memorial Hospital, North Durham Health Services, Oshawa General Hospital and Whitby General Hospital | June 1998 |

## HALIBURTON, KAWARTHA AND PINE RIDGE (Victoria, Haliburton, Peterborough and Northumberland Counties)

| | | |
|---|---|---|
| Haliburton, Kawartha and Pine Ridge Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | March 1998 |
| Haliburton, Kawartha and Pine Ridge Health Services Restructuring Report | Directions and Advice | June 1998 |
| Haliburton, Kawartha and Pine Ridge Health Services Restructuring Report: Supplemental Report | Notices of Intent to Issue Supplementary Directions — Governance Plan for the Northumberland Health Care Corporation | December 1998 |
| Haliburton, Kawartha and Pine Ridge Health Services Restructuring Report: Further Supplemental Report | Directions and Advice Governance Plan for the Northumberland Health Care Corporation | February 1999 |

## HAMILTON-WENTWORTH

| | | |
|---|---|---|
| Hamilton-Wentworth Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | November 1997 |
| Hamilton-Wentworth Health Services Restructuring Report | Directions and Advice | May 1998 |

## HASTINGS & PRINCE EDWARD COUNTIES (Belleville, Trenton, Picton, Bancroft)

| | | |
|---|---|---|
| Hastings & Prince Edward Counties Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | February 1998 |
| Hastings & Prince Edward Counties Health Services Restructuring Report | Directions and Advice | April 1998 |

## KENT (Leamington)

| | | |
|---|---|---|
| Kent County Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | October 1997 |
| Kent County Health Services Restructuring Report | Directions and Advice | February 1998 |
| Kent County Health Services Restructuring Report | Supplemental Report and Directions | October 1998 |

## LAMBTON (Sarnia, Petrolia)

| | | |
|---|---|---|
| Lambton County Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | November 1996 |
| Lambton County Health Services Restructuring Report | Directions and Advice | October 1997 |
| Lambton County Health Services Restructuring Report | Supplemental Report Charlotte Eleanor Englehart Hospital | July 1998 |

## LONDON

| | | |
|---|---|---|
| London Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | February 1997 |
| London Health Services Restructuring Report | Directions and Advice | June 1997 |
| London Health Services Restructuring Report | Rehabilitation, Long-Term Care and Sub-Acute Care Services & Notices of Intent to Issue Directions and Advice: Medical Human Resources Planning | July 1998 |

## METROPOLITAN TORONTO

| | | |
|---|---|---|
| Metropolitan Toronto Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | March 1997 |
| Metropolitan Toronto Health Services Restructuring Report | Directions and Advice | July 1997 |
| Metropolitan Toronto Health Services Restructuring Report | Notices of Intention to Issue Directions: Rehabilitation and Chronic Care Services | July 1997 |
| Metropolitan Toronto Health Services Restructuring Supplemental Report | Notices of Intent to Issue Directions: Service Integration Among the University Avenue Hospitals | March 1998 |
| Toronto Health Services Restructuring: Supplemental Report | Directions: Service Integration Among the University Avenue Hospitals | August 1998 |
| Metropolitan Toronto Health Services Restructuring: Supplemental Report | Notices of Intent to Issue Directions and Advice: Transfer of programs and services of Wellesley Central Hospital to St. Michael's Hospital | March 1998 |
| Metropolitan Toronto Health Services Restructuring: Further Supplemental Report | Directions and Advice: Transfer of programs and services of Wellesley Central Hospital to St. Michael's Hospital | March 1998 |
| Toronto Health Services Restructuring: Supplemental Report | Notices of Intent to Issue Directions: East Toronto Hospitals | September 1998 |

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|---|---|---|
| Toronto Health Services Restructuring: Supplemental Report | Directions and Advice: East Toronto Hospitals | January 1999 |
| Toronto Health Services Restructuring: Supplemental Report | Directions and Advice: Sunnybrook & Women's College Health Sciences Centre | February 1999 |
| Toronto Health Services Restructuring Report | Directions and Advice: Rehabilitation, Long-Term and Sub-Acute Care Services | April 1998 |
| **NIAGARA REGION** | | |
| Niagara Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | October 1998 |
| Niagara Health Services Restructuring Report | Directions and Advice | March 1999 |
| **NORTH BAY** | | |
| North Bay Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | October 1998 |
| North Bay Health Services Restructuring Report | Directions and Advice | March 1999 |
| **OTTAWA-CARLETON** | | |
| Ottawa-Carleton Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | February 1997 |
| Ottawa-Carleton Health Services Restructuring Report | Directions and Advice | August 1997 |
| Ottawa-Carleton Health Services Restructuring: Supplemental Report | Rehabilitation, Long-Term and Sub-Acute Care Services | July 1998 |
| Ottawa-Carleton Health Services Restructuring: Supplemental Report | Directions and Advice — Revised Timelines | December 1997 |
| Ottawa-Carleton Health Services Restructuring: Supplemental Report | Directions and Advice — Revised Timelines | June 1998 |
| Ottawa-Carleton Health Services Restructuring: Supplemental Report | Notices of Intent to Issue Directions and Advice Ambulatory Care Services | January 1999 |
| Ottawa-Carleton Health Services Restructuring: Supplemental Report | Directions and Advice Ambulatory Care Services | March 1999 |
| Ottawa-Carleton Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice Medical Human Resources Planning | June 1998 |

## RENFREW COUNTY (Pembroke)

| | | |
|---|---|---|
| Pembroke Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | December 1996 |
| Pembroke Health Services Restructuring Report | Directions and Advice | February 1997 |
| Pembroke Health Services Restructuring: Supplemental Report | Report of the Facilitator, Hugh Kelly | June 1997 |

## SAULT STE. MARIE

| | | |
|---|---|---|
| Sault Ste. Marie Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | January 1999 |
| Sault Ste. Marie Health Services Restructuring Report | Directions and Advice | March 1999 |

## STORMONT, DUNDAS AND GLENGARRY & PRESCOTT AND RUSSELL COUNTIES

| | | |
|---|---|---|
| Stormont, Dundas and Glengarry & Prescott and Russell Counties Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | May 1998 |
| Stormont, Dundas and Glengarry & Prescott and Russell Counties Health Services Restructuring Report | Directions and Advice | July 1998 |

## SUDBURY

| | | |
|---|---|---|
| Sudbury Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | September 1996 |
| Sudbury Health Services Restructuring Report | Directions and Advice | December 1996 |
| Sudbury Health Services Restructuring: Supplemental Report | Notices of Intent to Issue Directions and Advice<br>Governance Plan for the Sudbury Regional Hospital | March 1997 |
| Sudbury Health Services Restructuring: Supplemental Report | Directions and Advice<br>Governance Plan for the Sudbury Regional Hospital | May 1997 |

## THUNDER BAY

| | | |
|---|---|---|
| Thunder Bay Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | June 1996 |
| Thunder Bay Health Services Restructuring Report | Directions and Advice | October 1996 |
| Thunder Bay Health Services Restructuring: Supplemental Report | Redevelopment Option for Thunder Bay Regional Hospital | July 1997 |
| Thunder Bay Health Services Restructuring: Supplemental Report | Siting Option Change | October 1998 |

**WATERLOO REGION (Kitchener, Waterloo, Cambridge)**

| | | |
|---|---|---|
| Waterloo Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | May 1998 |
| Waterloo Health Services Restructuring Report | Directions and Advice | July 1998 |

**PARRY SOUND**

| | | |
|---|---|---|
| West Parry Sound Health Services Restructuring Report | Notices of Intent to Issue Directions and Advice | October 1998 |
| West Parry Sound Health Services Restructuring Report | Directions and Advice | December 1998 |

## Rural/Northern Network Restructuring Reports (19)

| | | | |
|---|---|---|---|
| Rural and Northern Hospital Network Report | Network #1 | — Simcoe/Muskoka | March 1999 |
| Rural and Northern Hospital Network Report | Network #2 | — Grey Bruce | March 1999 |
| Rural and Northern Hospital Network Report | Network #3 | — Wellington | March 1999 |
| Rural and Northern Hospital Network Report | Network #4 | — Haldimand | March 1999 |
| Rural and Northern Hospital Network Report | Network #5 | — Southwest — Strathroy Woodstock | March 1999 |
| Rural and Northern Hospital Network Report | Network #6 | — Northeast — North Bay/New Liskeard | March 1999 |
| Rural and Northern Hospital Network Report | Network #7a | — West Ottawa Valley | March 1999 |
| Rural and Northern Hospital Network Report | Network #7b | — East Ottawa Valley | March 1999 |
| Rural and Northern Hospital Network Report | Network #8 | — West Champlain | March 1999 |
| Rural and Northern Hospital Network Report | Network #9 | — Sault Ste. Marie Area | March 1999 |
| Rural and Northern Hospital Network Report | Network #10 | — Huron/Perth | March 1999 |
| Rural and Northern Hospital Network Report | Network #11 | — Northeast — Blind River/Elliot Lake | March 1999 |
| Rural and Northern Hospital Network Report | Network #12 | — Northwest — Marathon/ Hornepayne | March 1999 |
| Rural and Northern Hospital Network Report | Network #13 | — Northeast<br>— Timmins/ Kirkland Lake/Moose Factory | March 1999 |
| Rural and Northern Hospital Network Report | Network #14 | — Northwest<br>— Kenora/Fort Frances/Sioux Lookout | March 1999 |

| | | |
|---|---|---|
| Rural and Northern Hospital Network Report | Network #15 — Newmarket/Alliston | March 1999 |
| Rural and Northern Hospital Network Report | Network #16 — Cornwall Area | March 1999 |
| Rural and Northern Hospital Network Report | Network #17 — Brantford Area | March 1999 |
| Rural and Northern Hospital Network Report | Network #18 — Brampton/Orangeville | March 1999 |
| Rural and Northern Hospital Networks: Advice and Recommendations to the Minister of Health | Final report — confidential advice to the Minister | February 2000 |

## Planning & Policy Reports (16)

| | | |
|---|---|---|
| Building a Better Health System for Ontario | Overview of mandate, process and membership of the HSRC | 1997 |
| A Vision of Ontario's Health System | A discussion document — draft vision of the future health system | January 1997 |
| Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies — Home Care, Long-Term Care, Mental Health, Rehabilitation and Sub-Acute Care | A discussion paper (draft planning guidelines) | July 1997 |
| Medical Human Resources Fact Finders Report to the Health Services Restructuring Commission | A discussion paper on medical resources issues | January 1998 |
| Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long-Term Care, Mental Health, Rehabilitation and Sub-Acute Care | Final HSRC planning guidelines | April 1998 |
| Co-ordinating And Consolidating Specialized Paediatric Services In Ontario | A Confidential Report to the Minister of Health re: advice on consolidating tertiary/ quaternary paediatric services | February 1999 |
| Advice to the Minister of Health on Building A Community Mental Health System in Ontario | HSRC advice to the Minister of Health — strategies to support PPH divestment | February 1999 |
| Better Hospitals, Better Health Care for the Future | Summary report on hospital restructuring (1996-1999) | April 1999 |

| | | |
|---|---|---|
| From Here to Where?. . . defining the 'next steps' in health system reform | A discussion paper — summary of the key messages that arose from a series of round table discussions hosted by health provider groups/organizations | May 1999 |
| Ontario Health Information Management (IM) Action Plan — the top priority for building a better health system | Phase 2 policy document/Advice to the Minister — a long-term vision for an integrated health information network with an electronic consumer record at its core. A total of 22 health IM initiatives are included in the three-year action plan to address: improving consumer information; improving health services delivery at the point of care; improving health services management. | June 1999 |
| Implementing Integrated Health Systems In Ontario: A review of legislative/regulatory implications | A discussion paper — possible legislative changes required to support the development of integrated health systems (IHSs) in Ontario. | July 1999 |
| Reforming Ontario's Health System: key considerations | A discussion paper — insights into the following questions:<br>• What are current public perceptions about the health system and how should these be factored into planning for future reforms?<br>• What are the political obstacles to achieving greater integration/co-ordination of health care services?<br>• Are their processes which offer better prospects for mobilizing a consensual approach to health policy reform? | August 1999 |
| Primary Health Care Strategy | Phase 2 policy document/Advice to the Minister of Health | December 1999 |
| Academic Health Science Centres: A Perspective on a Future Role | Phase 2 Advice to the Minister of Health — advancing the role of AHSCs | March 2000 |
| HSRC's Strategy for Improving Health System Performance | Phase 2 policy document/Advice to the Minister — a process and strategy for assessing improvements in health system performance | March 2000 |
| Advancing Community Integration: Experiences and Next Steps | Phase 2 policy document — a summary of experiences and lessons learned in working with communities to support and promote local integration | March 2000 |

## Additional Reports (2)

| | | |
|---|---|---|
| Policy Considerations in Implementing Capitation for Integrated Health Systems | A policy synthesis containing recommendations and advice based on research commissioned by the Canadian Health Services Research Foundation in partnership with the HSRC. (Published and Distributed by CHSRF) | 1999 |
| Capitation Formulae for Integrated Health Systems | A policy synthesis containing recommendations and advice based on research commissioned by the Canadian Health Services Research Foundation in partnership with the HSRC. (Published and Distributed by CHSRF) | 1999 |

This report was released by the Ontario Health Services Restructuring Commission on March 27, 2000.

Effective April 1, 2000, hard copies of this document can be obtained free of charge from the Canadian Health Services Research Foundation/Fondation canadienne de la recherche sur les services de santé.*

The executive summary can be found on the foundation's website at http://www.chsrf.ca/englishdocument-library/index.html (library series).

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As well, full text of this publication can be found as a PDF file on the HSRC's website at http:// www.hsrc-crss.org. This website will be operated by the Ontario Ministry of Health and Long-Term Care until December 31, 2000.

Version française disponsible.

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